HEALTHCARE AND SMALL BUSINESS: REAL OPTIONS FOR COLORADO BUSINESSES

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON WORKFORCE, EMPOWERMENT & GOVERNMENT PROGRAMS

OF THE

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HEALTHCARE AND SMALL BUSINESS: REAL OPTIONS FOR COLORADO BUSINESSES

THURSDAY, AUGUST 10, 2006

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON WORKFORCE, EMPOWERMENT, AND GOVERNMENT PROGRAMS
COMMITTEE ON SMALL BUSINESS
Washington, DC

The Subcommittee met, pursuant to call, at 1:00 p.m., in Loveland City Council Chambers, 500 East 3rd Street, Loveland, Colorado, Hon. Marilyn Musgrave [Chairman of the Subcommittee] presiding.

Present: Representative Musgrave.

Also Present: Representative Shadegg.

Chairman MUSGRAVE. The hearing on the Subcommittee on Workforce, Empowerment, and Government Programs will come to order. Thank you all for being here today. We appreciate that so very much. We are going to examine healthcare choices for America's small businesses, their employees, and working families.

Before I begin, I would like to thank my friend and very respected colleague for joining me here today, John Shadegg. Of all days to be flying, John. This has been a most interesting one and I am glad it went well. I want to thank you very much for making the effort to be here.

Mr. SHADEGG. My pleasure.

Chairman MUSGRAVE. John was first elected in 1994 and he quickly established a reputation in Congress as a leading advocate for reduced government spending, federal tax relief, and the re-establishment of state and individual rights. He has proven to be a leader on healthcare issues.

From 2000 to 2002 he was the Chairman of the Republican Study Committee, the largest conservative organization in the House of Representatives. Under his leadership there was dramatic growth from 40 to more than 70 members and it has become the most influential and respected force in the U.S. House shaping conservative policy for the country.

In 2005 John was elected by his peers to serve as Chairman of the House Republican Policy Committee, the fifth ranking position in the House leadership from 2005 to 2006. At the time he was the only member of the Republican class of 1994 serving in House leadership. Again, I just want to thank you for being here as we address this important topic today.

All Americans want reliable, high-quality, and reasonably-priced healthcare that will be there when they need it. One of the most stressing statistics we hear each year is the rising number of Americans who live without health insurance currently estimated at 45 million people. Of those without health insurance about 60 percent are small business owners, employees of small businesses, and their families.

As healthcare costs continue to rise, fewer employees and working families will be able to afford coverage. In Congress we must look at this pressing problem and find solutions that will create an environment so that those who need health insurance cannot only find the coverage they need but, more importantly, afford it. We need to be working towards the healthcare delivery system method that works best, not just what we have always done.

A simple look at the current health landscape shows that the system is not working. The thing that we will focus on today will be four proposals that this Congress has begun to work on to help Americans get the coverage they need at a price they can afford.

These proposals are the establishment of Association Health Plans, as we call them AHPs, increasing the availability, use, and ease of Health Savings Accounts, we call those HSAs, reforming the medical liability system, and examining Congressman John Shadegg's common sense legislation H.R. 2355. He will tell us all about that, the Healthcare Choice Act.

On July 26, 2005, the House of Representatives passed H.R. 525, the Small Business Health Fairness Act of 2005. That was legislation that would establish federally regulated Association Health Plans with a strong bipartisan vote. That was the 7th time the House had passed such legislation. I am confident, though, that real progress on this legislation will be made in the Senate this year.

AHPs would allow small businesses to band together across state lines through their membership in an association to purchase more affordable health insurance. Unions and large corporations already have the ability to do this so it makes sense to me that we should allow small businesses to have the same opportunity.

Health savings accounts are a new way that people can pay for a medical expense not covered by insurance or other reimbursements. Eligible individuals can establish and fund those accounts when they have a qualifying high-deductible health plan and no other health insurance with some exceptions. These accounts have significant tax advantages. The contributions are deductible. Withdrawals used for medical expenses are not taxed, and account earnings are tax exempt and unused balances can accumulate without any limit.

President Bush has proposed several improvements to HSAs such as allowing Americans who HSA qualified insurance policies on their own to have the same tax advantages as people who obtain health insurance through their employers and eliminating all the taxes on out-of-pocket spending through HSAs.

An additional area that Congress and the President have worked on together is tort reform for the medical community. American patients are losing access to healthcare because of the nation's out-

of-control legal system enforcing physicians in some areas to retire early.

I was an elected to Congress with three doctors and some of the most poignant testimony you will hear are from doctors that come from states that have enormous problems with the tort system.

Right now it is estimated that we have 21 states that are in a full-blown medical liability crisis and in 2002 there were 12 so we see the growth. In these crisis states patients continue to lose access to care. The rural areas of the 4th District, like many other districts around the nation, people have to drive over long distances, especially in the area of OB/Gyn when women have babies having to drive 200 miles to see a doctor it gets very burdensome.

Meanwhile, the high-risk specialists no longer can provide trauma care or perform complicated surgical procedures. This excessive litigation and high medical malpractice rates have added to employers' healthcare costs and have spurred some providers to err on the side of caution that comes at the expense of both health plan dollars and patients receiving unnecessary service.

This issue isn't just about physicians. It cuts across the healhcare sector. Hospitals need physicians to admit patients. Companies that manufacture medical devices and pharmaceuticals need physicians to use and prescribe their products. Similar to the AHP legislation, the House passed more healthcare related issues in H.R. 5 that help efficient accessible low-cost timely healthcare, or Help Act of 2005, and that happened in July of 2005. The Senate is continuing to debate this critical legislation.

Another proposal to help Americans find and afford healthcare is legislation introduced by my colleague, John Shadegg, H.R. 2355. Again, that is the Healthcare Choice Act of 2005. Under this legislation consumers would no longer be limited to purchasing policies dictated by their state's regulations and mandated benefits. Instead they can pick from a variety of insurance policies qualified in one state but offered for sale in multiple states.

When I served in the Senate with Mark Hillman we dealt with many mandates in committees and we saw the policies in Colorado loaded up. This would be a solution to that problem that drives up the cost of the policy. We know, there is not one solution to a problem that is as complicated and as complex as what we are facing with 45 million Americans without health insurance.

Small businesses and their employees are in a critical situation with finding new ways to increase health insurance coverage and we will look at many proposals today that have been offered. I am eager to hear from our witnesses today. I thank you very much for being here.

Our first witness is Mr. Matt Fries. He is President and CEO of the Professional Document Management from Fort Collins, Colorado. I think I will just introduce all of you, if I may, Mr. Fries.

Excuse me. You know what I forgot? My Congressman from Arizona that came to be with us. I'll introduce the witnesses in a moment. Forgive me, Mr. Shadegg.

[Chairman Musgrave's opening statement may be found in the appendix.]

Mr. SHADEGG. The order doesn't really make much of a difference.

Thank you very much, Madam Chairman. I want to commend you and the Full Committee Chairman, Mr. Manzullo, for your focus on healthcare. This is a critical issue that faces our entire nation. I have a written opening statement which, with your permission, I will put in the record and just briefly kind of summarize a few comments.

Both you and Chairman Manzullo have been leaders on the issue of healthcare reform. I have a passion for healthcare reform because it is affecting so many American businesses and it is damaging our economy. Indeed, as I think you will recall, just before we left Washington for the August district work period, the Chairman of the Committee, Mr. Manzullo, made an impassioned plea for America to deal with the problems confronting small businesses and, in particular, the rising cost of healthcare. He talked about a personal story. His brother, who is in the restaurant business, was forced out of business by rising healthcare costs. I want to commend you as a leader in this field.

As you mentioned in your opening statement, there is no one answer to this problem. The four bills that you have picked for this hearing, I think, are key parts of the solution to this problem. I would like to thank all the witnesses for being here. I would like to thank the people in the audience who are paying attention and looking at this issue.

Association Health Plans are an idea whose time has come and we simply, as you pointed out, need to get the Senate to reflect the will of the American people. It is a device by which small employers could get together and buy insurance by pooling together and getting the larger purchasing mechanisms thereby bringing down the cost of their health insurance and making them more competitive.

Health Savings Accounts, I think, go to the heart of one part of the problem which is we have told the American people that they are not personally responsible for their own healthcare and for the cost of that healthcare. HSAs put them back in the driver's seat which is a key part of what I hope to do in healthcare reform.

There are many pieces to this puzzle. Liability reform, as you mentioned, is a huge one. Unfortunately, we have tried and tried again to address the problem of liability reform in Washington again with no success, kind of steadfast opposition from those who believe the current tort system is serving the interest of the American people. I am one of those who believes that an injured patient should be able to recover, but I also believe that we have an out-of-control tort system. I might note you kindly did not mention my prior occupation. I call myself a recovering lawyer, though I did not practice tort law.

I will just briefly try to, if I could, mention the Healthcare Choice Act. It is an idea that not many people are familiar with. I will take a couple of minutes to describe its advantages and strengths. I would suspect that it having gotten very little attention in the national media, probably many members of even your panel haven't heard of this notion or the idea behind it. If I could, I will try to just briefly summarize how it would work.

The insurance market, and I think everyone knows, is divided into different segments. Most Americans get their insurance

through their employer. In addition, many Americans get their insurance or their healthcare through government programs, either Medicaid or Medicare. But there is a segment of our population that buys their health insurance in what is called the individual market. That means they don't get it from their employer and they have to go out and buy it individually.

Right now that is the segment of the market that is still regulated by the states. I guess as a states rights person and someone who believes that the federal government located as it is far away in Washington, D.C. isn't the best regulator. When looking at the healthcare reform issue I decided we ought not move more of healthcare reform regulation or healthcare regulation to Washington, D.C. Let's try to lead it with the states.

At the same time, as you pointed out, the current system for individual health insurance sales is overburdened by state regulatory practices and by mandates. Just a handful of years ago there were across America some 50 to 200 mandates, benefit mandates. Things like you must cover podiatry or you must cover various types of care, emergency room care, cancer screening, those kinds of things.

As you pointed out, the state legislatures have been inundated with demands for more and more mandated benefits. I doubt if many people realize that, for example, today podiatry is required to be covered by any insurance policy sold in the state of New York. Acupuncture must be covered in any policy sold in 11 different states, California, Florida, Montana, and on.

Massage therapy is a mandated benefit in the policies sold in five different states. Everyone might say it is a good idea to cover these kinds of services but the problem is every time you mandate an additional benefit that must be covered by an insurance policy, you raise the cost of that policy.

The other issue is that because in the current individual market an insurance policy must be filed with and qualified for each state's laws, any insurance company that wants to sell a policy in all 50 states has to write that policy, has to write a policy that meets the state laws of any state they want to sell in. If they want to sell in my home state of Arizona, they have to write a policy that meets Arizona law. If they want to sell in Colorado, they must write a policy that meets Colorado law.

That means a huge regulatory burden of meeting the laws of all 50 different states. The concept behind the Healthcare Choice Act is pretty simple and straightforward. Given that most state's insurance laws are relatively similar, it says that an insurance company can take a policy, bring it to Colorado, for example, qualify it for sale under Colorado law, and then take that policy to any one of the remaining 49 states, simply file with the insurance commissioner in that state and then offer that policy for sale.

There is a huge regulatory burden that is lifted. But being interested in having consumers protected by local enforcement or local regulatory protection, we then said that if a policy was written to comply with Colorado law and then taken and filed in Arizona and sold in Arizona, the Arizona insurance commissioner could enforce the terms of the policy on behalf of Arizona consumers.

What this would really mean is that the regulatory burden for getting a policy in the market would come down dramatically. The

number of mandates included in a basic policy would go down quite dramatically lowering the cost of health insurance and, yet, consumers would remain protected because their own insurance commissioner could protect them.

In most states, and I believe this is true of Colorado, the number of insurance companies selling policies on the individual market is a handful, three to five. There is virtually no competition. Were you to enact the Healthcare Choice Act, which I hope we will get a vote yet this year in Congress, and has passed the Commerce Committee on which I serve, there would be literally dozens more policies for sale here in your congressional district because it would be so much easier to bring a policy to the market and, therefore, more competition hopefully producing lower cost.

That gives people a little bit of an idea what the Healthcare Choice Act does. It did clear the Energy and Commerce Subcommittee and it is waiting for further action so we are anxious. I want to thank you for continuing to support healthcare reform so that Americans can get high-quality healthcare at an affordable price.

Chairman MUSGRAVE. Thank you. I remember when you came into my office to ask me to co-sponsor that legislation. You got a little bit out of your mouth and I said, "Does it get us out from under all the mandates?" You said, "Yes." That is what I wanted to hear right away. Thank you for being here.

I would like to introduce the witnesses and then we will start with Matt. Again, the first one is Mr. Matt Fries, President and CEO, Professional Document Management from Fort Collins. Then we have Chris Boesch, Exodus Moving and Storage from Fort Collins. There you are. Thank you.

Next up is Mark Hillman. I served with Mark in the state legislature. It is very good to see you and I know that you were very knowledgeable and worked very hard on bringing down the cost of healthcare. I appreciate those efforts.

Deb Tamlin. It is good to see you. I thank you for being here today, a broker from ZTI Group in Fort Collins. Gail Snyder down there on the end, Snyder Insurance Agency, Loveland, Colorado. Dale Roberts from the Loveland Chamber, Loveland, Colorado. Fred Liske, General Manager, American Eagle Distributing Co. It is very good to see you. Dr. Jack Cletcher. We are happy to have you here today from Berthoud, Colorado. And Allan Jensen, Colorado Association of Health Underwriters.

I think we will just actually go in the order that you are seated. That will be fine. Matt, we will start with you. We will adhere to the clock so Mr. Shadegg can get off to DIA and fight the good fight to get back to Arizona. Thank you.

STATEMENT OF MATT FRIES, PROFESSIONAL DOCUMENT MANAGEMENT

Mr. FRIES. Very good. Good afternoon Chairman Musgrave. It is a pleasure to see you. Welcome to Northern Colorado Congressmen Shadegg. Thank you for holding this hearing and for your leadership to find ways to make health care coverage affordable to small businesses.

My name is Matt Fries, and I am the owner of Professional Document Management located in Fort Collins. My company is in the paper and electronic records storage and destruction business, and we employ 13 people, 10 full-time and three part-time.

Like most small, independent business people, I don't typically look to Washington, D.C. to solve my problems. Most of us generally operate from the point of view that less government is the best government. And when it comes to affordable healthcare, government provided healthcare known as universal care is absolutely not the answer.

Yet, the current health care coverage system isn't working all that well, especially for small businesses. My company is pretty typical. The people employed at PDM work very hard and do a great job. They care about our customers and serve them well and for their success, they deserve to have access to first rate health and medical care when they need it.

However, due to the high cost of health insurance premiums, that is extremely difficult for me, if not financially impossible. Currently, we are unable to provide any level of health care insurance for our employees.There is a direct relationship between the increase in health care and the cost of health care coverage. New medical technologies and new procedures can lead to increases; however, from where I sit there appear to be two major cost-drivers. One is litigation and the other is state mandates.

Because my business serves the medical community, I know a lot of physicians, and they struggle with crushing malpractice insurance rates. Excessive litigation and consequent high medical malpractice insurance rates cost all of us. Caps on non-economic damages and punitive damages would go a long way to stem rising costs. This is beyond the scope of H.R. 2355 but deserves your further attention.

Regarding mandates, they are a major cost factor. For decades states have micro-managed the health insurance industry. State legislators require insurance companies or health plans to cover specific services and by doing so they drive up costs for all of us. The worst offender is Minnesota with over 60 mandates. We are fortunate in Colorado to "only" have 19. According to the Council for Affordable Health Insurance, state mandates add between 20 and 50 percent to the cost of health insurance.

This leads to another cost-driver: lack of competition. Price and competition are inextricably tied together. A few large insurance companies dominate the state markets meaning that there is very little real competition in thehealthcare insurance coverage marketplace. Where little competition exists in any industry, there is no incentive to keep prices down. I think H.R. 2355 could have the effect of creating a national health insurance market. New competition will drive down costs.

Another issue is lack of flexibility in the health insurance marketplace. Even in my small company employee needs vary widely. The younger employees tend not to care much about health and medical insurance, while middle-aged and older workers do. It is difficult for us to qualify as a "group" when the young workers don't want to pay to participate in an expensive one-size-fits-all plan with features they don't want.

Also, consumer-driven options like Health Savings Accounts, while a huge step in the right direction, need to be detached from employer-provided policies. HSA purchasers should be allowed to purchase any type of health plan and get a tax credit for doing so.

The concept in H.R. 2355 concerning "small business health plans" is excellent. By allowing small employers to purchase coverage through bona fide associations, small guys like me will have the same advantages that unions and big employers have. By banding together, small businesses will realize economies of scale, increased bargaining power, savings from administrative efficiencies due to having just one set of rules, flexibility in the design of the coverage and increased competition in the health insurance markets.

Small firms and their employees will see lower insurance premiums as risks are spread across a larger pool of people. Small Business Health Plans would give the little guys the same preemption from costly state mandates now enjoyed by the big guys under the Employee Retirement Income Security Act (ERISA).

I am convinced that fostering interstate commerce in the health insurance market will increase competition and improve consumer choices just like interstate banking has done.

In summary, small employers like me want to provide health insurance to our employees without the cost and inflexibility of expensive state mandates. We want to encourage further development of consumer-driven health plans like Health Savings Accounts. We want to see choices for our employees in terms of coverage they want rather than being forced to buy one-sized-fits-all coverage.

Chairman MUSGRAVE. If you could just wrap up.

Mr. FRIES. You bet. In closing, as a small employer, as stated earlier, I don't look to Washington, D.C. to solve my problems. I don't look to you for handouts. Congress can help, however, by improving the health care market. H.R. 2355 is a big step in the right direction. Thank you again for your leadership on this issue and for listening to my testimony.

[Mr. Fries's testimony may be found in the appendix.]

Chairman MUSGRAVE. Thank you for your good testimony.

Now we will hear from Mr. Roberts representing the Chamber of Commerce from Loveland.

STATEMENT OF DALE ROBERTS, LOVELAND CHAMBER OF COMMERCE

Mr. ROBERTS. Yes. Thank you all for taking your time to be with us today. My name is Dale Roberts. I am Executive Vice President of Front Range Bank. Today my hat being worn is the Chairman of the Chamber of Commerce here in Loveland.

Chairman MUSGRAVE. Could I ask you to pull your microphone a little closer if that is possible?

Mr. ROBERTS. Okay. Is that better?

Chairman MUSGRAVE. Thank you.

Mr. ROBERTS. Okay. My speech won't be five minutes. I just wanted to share with you the issues that our Chamber is involved with and the things we have been trying to do possibly looking to you to give us some other guidance and leadership.

The Loveland Chamber actually has become a bona fide association as spoken to a little bit by Matt. We are currently working with local healthcare providers to try to get something going with them to provide insurance coverage for small businesses.

As a matter of fact, it is kind of frightening in some ways. Loveland seems to be a big city. However, of our 850 members in the Loveland Chamber of Commerce, 85 percent of those are four employees or less. We are concerned because we have a lot of those companies who are frankly running uninsured We don't currently know any other way than try to make the Chamber, if you will, a bona fide association tying our Chamber membership into some kind of a healthcare program. Hopefully with state laws and others we will be able to solve that problem and use our association to help that very small businessman.

Again, thank you for my testimony and thank you for being here.

Chairman MUSGRAVE. Thank you.

Now we will go to Ms. Chris Boesch from Exodus Moving and Storage, Fort Collins. Thank you for being here before the Committee today.

STATEMENT OF CHRIS BOESCH, EXODUS MOVING & STORAGE

Ms. BOESCH. Thank you. I want to also thank you all for being here and having this very important discussion. We have 60 employees. We do not provide health insurance. We do provide dental for $11 per month per employee which is fabulous. We give our guys a few dollars a month towards preventive maintenance such as vitamins, to go to a gym, that sort of thing.

The profit margin in our industry is four percent. The lowest healthcare that is available out there, Anthem recently went from $100 to $50 as a minimum that an employer can contribute to an employee. You can have a 60 percent amount of employee participation instead of 75 percent. That is supposed to be good news.

Unfortunately, it is not good news. The reason being that with 60 employees $50 a month you are looking at $3,000 a month and that is if it doesn't go up next year and the year after that. That is over one percent of my income and I have a four percent margin.

Not to mention that it is about $200 a month per employee and there is no way that my guys that make between $9 and $16 an hour are going to be able to afford $150 a month. It is a very difficult situation. They would like healthcare even though they are young for both them and their families.

I am just going to throw out kind of an ad question that I don't expect you to respond to right now, but how is it that healthcare became the responsibility of businesses.

Chairman MUSGRAVE. That is a good question.

Ms. BOESCH. Okay. I think if we could go back to that basic and talk from that point of view, I think that would be very important.

Secondly, I am going to offer kind of a pie in the sky resolution. I believe in pie in the sky ideas because I think if you don't reach, you can never attain. One of the things we all know that in addition to water, food, shelter, and education everyone should have access to a doctor. We also know that our European counterparts have managed to do that for their citizens. We are a richer country and we don't seem to have that which is really, I think, sad.

I think there is no reason why Colorado can't be a pioneer. One of the things that I would suggest is that health insurance companies, like many companies, are there to make money. I don't think they are necessarily there to help patients or help hospitals. The local hospital here 60 to 70 percent of their income comes from the foundation from Medicare and from Government subsidies.

Thirty to 40 percent comes from healthcare insurance and healthcare insurance and healthcare insurance companies don't tend to pay the full price of the services that the hospitals provide so the hospitals get short-cutted when working with health and insurance companies, not mentioning all the different types of people that everyone has to go through to make that happen.

What about the idea of getting rid of the middleman? I am going to the concept of a partnership between businesses, residences, and the hospital. Perhaps there is a monthly fee that is charged to every resident based on their income that is a percentage base. Also health tax could be connected to a property tax so that, again, you are looking at a fairness factor, if you will.

But not to be completely ignorant in that if we have a huge train wreck or some big horrible catastrophe, somehow the cities or the state would have to be covered for something massive so have a huge umbrella policy through an insurance company along those lines. That is just kind of my pie in the sky idea that I wanted to throw out.

I think that is all I have to share. Thank you very much.

Chairman MUSGRAVE. Thank you very much. We discussed that we might talk about tax rates in those European countries, too, because somebody does pay for it.

Fred, I am glad to have you here today and we are looking forward to hearing from you.

STATEMENT OF FRED LISKE, AMERICAN EAGLE DISTRIBUTING COMPANY

Mr. LISKE. Thank you. My name is Fred Liske and I am General Manager of American Eagle Distributing. I am honored to be here today because this is a very timely topic for our company and everybody on the panel's company. We just came off of renewing coverage for our employees so we are fresh off the fax.

I am going to tell you a little bit about our business to start with, the industry that we participate in, and then we will just kind of move forward from there.

American Eagle Distributing has been around a long time. It is about a 30-plus-year business in the community. We are one of 1,900 American beer distributors across this country. American beer distributors are generally family-owned, independent companies, relatively small business, generally 50 employees, about $14 million a year revenue. We have a million dollar payroll.

We are a little bit bigger here than the average wholesaler. We have about 120 employees, $50 million a year in annual revenue, and about $4.7 million in payroll. Ironically we are a member of the National Beer Wholesalers Association and one of the hot topics of discussion right now is healthcare for our employees. It is absolutely crushing us when we take a look at the cost. We just recently, like I said, renewed our policy.

What I want to do is take you through real quickly a little bit about us as a company. We haven't had an issue with getting insurance for our employees. We have been around a long time and we have been pretty good at that but we are having an issue as far as cost. We have to contain those costs and they have gone up substantially year over year.

As we just renewed our healthcare benefits, some of the things that we looked at were the benefits and costs of multiple insurance products, the availability of in-network providers, the deductibles and the maximum amount for our employees, co-pays, specific stop loss maximums, allocation of premiums for commissions, fees, and administration expenses.

I will speak up a little. Anyway, as general manager I got to kind of see everything and I think like most small businesses we have a handful of staff or executive members that have to do everything. That is a lot of things that we have to review. We are not experts in all these and a lot of issues that we have to deal with in communicating insurance to the employees.

Moving on, prior to shopping, bargaining and increasing our insurance we had to increase our stop loss amounts this years. We did that also last year. What I specifically mean by that is we are partially self-insured. That means as a company we continue to take more and more of the risk.

Now, what we are hedging on is that we don't have a calamity or a series of employees that have serious illnesses or injuries because that will definitely impact our bottom line. The reason we chose to do that as a company, it was the only way of keeping our insurance costs in line for our employees to afford.

To give you an example, the increase in the cost of our insurance from 2002 to 2006 was basically 9.7 percent. We kept that in the 6 percent range as a company by again being partially self-insured and raising the stop loss protection for our employees. In 2005 our healthcare benefits represented 10 percent of our overall payroll cost. If you figure about $4.7 million in payroll, $470,000 for healthcare costs for the employees.

We feel that again we work, just as Chris alluded to, on a very slim margin. Extremely slim. We continue to see margins going down in our industry. As we do that, we look at the $460,000 as being obviously an extreme cost of doing business.

There is something else that we want to bring up that we found is very interesting, and that is while we offer insurance we know a lot of small employers don't. Something that we found, especially with our younger employees, they don't understand the benefit of the insurance that we offer. As a company and working with other beer wholesalers we have to educate.

We have a lot of young employees, as you can imagine, that are putting the beer away doing that type of stuff and they will literally jump ship for 50 cents an hour to another competitor that doesn't offer insurance benefits. Again, when they get a little bit older and they actually use the benefits, they see the value but that is just something that we thought we would bring up because it is something we deal with in the company every single day.

I thought I would bring up just a couple things also in closing. We try to stay pretty active in the community and we got some sta-

tistics which we included in our packet for NCMC, Northern Colorado Medical Center. The interesting thing that we brought up, and I want to read this. For 2005 their bad debt was 9.7 percent of their total operating revenue. Basically what they are telling us is 20 percent of the people that walk in their door to the emergency room have insurance.

If we as a company—and remember we are a $50 million company. If we as a company had bad debt of 9.7 percent of our operating revenue, we would be out of business. Doors would be closed and we would be gone. Again, something to bring up also as a point.

Kind of in closing I wanted to bring up that we think that the interstate commerce and health plans and the potential larger pooling would be absolutely phenomenal for us because what we look at is obviously we think it would reduce the insurance administrative cost. We think it would add more value focused in a network of providers. Obviously increases competition. We might be able to have more like companies such as beer distributors within a pool. We feel that in the long run that may help keep costs within the realm.

Anyway, that is what we had in closing and then in the packet we include some backup data. Thank you.

Chairman MUSGRAVE. We will submit all of that to the record. Thank you.

Mark Hillman, we are very glad to have to have you with us today. We look forward to hearing your testimony.

STATEMENT OF MARK HILLMAN, FORMER STATE SENATOR

Mr. HILLMAN. Thank you, Madam Chairman, and Congressman Shadegg from Colorado. My name is Mark Hillman. I am the owner and operator of Hillman Farms at Burlington and former Colorado Congressman.

It has been said that insanity is doing the same thing over and over again and expecting different results. That maxim could certainly apply to attempts by lawmakers and regulators to "fix" the health insurance market. If I could wave a magic wand and compel Congress do absolutely anything to the health insurance market, I would simply ask them to undo everything Congress has done to the health insurance market.

In fact, apart from licensing insurers to require financial stability, even most state level regulations simply replace old problems in the marketplace with well-intended but politically-driven marketplacedistortions. These distortions replace old problems that could be affected and corrected by the choices of millions of consumers and erect political obstacles that are exceedingly difficult to correct.

Colorado's small group market for health insurance has been struggling for many years. In 1994, 84 carriers offered small group coverage in Colorado. Today, 10 carriers constitute 96 percent of our market. From 2000 to 2005, the number of lives covered in the small group market declined from 538,000 to 358,000 and the number of employer groups enrolled in small group plans fell from 70,000 to 46,000.

Much of this decline finds its roots in so-called "reforms" of the past beginning with: Community rating. Prior to enactment of "community rating" in Colorado premiums were directly related to the health of each consumer. Legislators enacted community rating in order to protect small business from wildly fluctuating premiums and to keep insurance affordable for consumers with pre-existing health problems. Unfortunately, this replaced wildly-fluctuating costs with rapidly-increasing costs and disproportionately shifted costs to healthy consumers, causing many of them to simply leave the market.

Look at it this way. If you and I go to lunch everyday and we both pay $10 and I get an $18 steak and you get a $2 cheese sandwich, how long are you going to like to subsidize my steak and be satisfied with your cheese sandwich? That is exactly what the community rating does.

It gets worse, because when healthy consumers leave the market, the high-risk consumers who remain now must bear an even higher cost. In 2003, Colorado took a modest step toward restoring market based premiums by allowing insurers to offer discounts of up to 25 percent to employer groups, thereby making premiums more affordable for health groups. As the sponsor of that legislation, however, I will tell you that we need to give insurance carriers even greater flexibility, perhaps up to 50 percent, in order to allow them or require them to compete for consumers' business and to attract healthy consumers back into the market.

The second distortion is guaranteed issue. Congress compounded the problems associated with state-level community rating by mandating "guaranteed issue" to anyone whose employer provides group health insurance. The rationale for this was simple, that no one should be denied health insurance coverage because of preexisting conditions.

The distortion this created is that employees can now decide to forego health insurance coverage until they actually need health care. For young people it makes perfect sense for them to drop their health insurance until they have an outstanding need.

Lastly, mandated coverage. Everyone who purchases health insurance through the small group market in Colorado is required to pay for, by some counts, 17 and by others as much as 24 mandated coverages, regardless of whether they want or need them.

My favorite example is that by law everyone, that is everyone, men, women who plan not to have children, and women who are beyond child-bearing age have to purchase pregnancy and maternity coverage. Incidentally, pregnancy and maternity coverage for an ordinary pregnancy with no complications is now mandated by federal case law so consumers cannot choose to pay for this out of pocket.

This illustrates perhaps the biggest problem with mandated coverage. Most mandates require coverage for things like prostate or breast examinations. From a preventative standpoint, those precautions are certainly wise. However, the purpose of insurance is not to be a compulsory savings plan for medical expenses that can be anticipated. The purpose is to share the risk for "insurable events" costs that are unanticipated, unavoidable and difficult or impossible to budget. Mandating coverage for preventative mainte-

nance simply requires us to use the middle man which increases those costs.

Lastly, if I were to make a few suggestions, I would suggest that we make health insurance premiums fully tax deductible for everyone. Most business owners or managers do not want to be in the position of choosing benefits for their employees. The only reason they have to do that is because of the uneven treatment by the Internal Revenue Service code. This is manipulative, not to mention economically insane because it removes the ability to make choices about cost and coverage from the very people to whom the market should respond.

I think a refundable tax credit would be even a better step. Lastly I would suggest that you leave regulation of health insurance to the states. Although I am intrigued by the prospect of congressional legislation to allow consumers to purchase health insurance from carriers in any state, the one concern I do have is that Congress will then be unable to resist the temptation to meddle in this new national market and instead impose costly mandates and burdensome regulations at the national level which then will be virtually impossible to reform. Thank you.

[Senator Hillman's testimony may be found in the appendix.]

Chairman MUSGRAVE. Thank you, Mark.

Now we will hear from Dr. Jack Cletcher. Thank you for being here today.

STATEMENT OF DR. JACK CLETCHER

Dr. CLETCHER. Thank you very much. It is a great honor to be here, Congressman Musgrave and Congressman Shadegg. It is a great pleasure to have the opportunity to talk to you. That is basically what I am going to do. I have written my testimony. It is in here. I chose to testify on my own behalf from my own experience. I do have, however, a great background in some of these issues having been a member of the House of Delegates, the American Medical Association for several years.

I have been integral in the development of the physician and patient advocacy of the Colorado Medical Society. I have served various positions in the State Medical Society and the County Medical Society. I am also an representative of the American Academy of Orthopedic Surgeons at the AMA and on various other councils serving on their ethics committee for a long time. All of these things are very familiar to me. Actually, my testimony as written is somewhat moot because of Congresswoman Musgrave's excellent summary of the problem covering most of the issues that I think are contributory to the cost of healthcare. I will focus my testimony again as an individual on the issue that I was asked to do which is the contribution of the cost of medical liability to the increase in the cost of medical care in the United States.

Briefly, it is a well-documented fact that the cost of medical liability insurance has risen exponentially in the past 20 years. It affects everybody involved in the healthcare production. Equipment manufacturers, doctors, nurses, hospitals, any provider has experience an enormous increased in their cost of liability insurance at all levels. People don't realize the cost to them.

For example, the cost of a total hip charged to the patient is $6,000 or $8,000 for just the piece of iron that they put in there. The liability on the manufacturer of that product is undisclosed. You can't get any of the manufacturers to really tell you how much it is but I know from private conversations it is probably close to 40 percent of that cost purely for liability issues.

Who pays for this? Well, it is YOU, the patient. You pay for it. Any care that you get and any service that you get, materials that you receive in the healthcare industry through the health insurance that you buy and everything you ultimately pay for whether it is out of your pocket or perhaps your employer would have been able to pay you a great deal more money had they not had the mandate before issuing insurance.

It is a benefit that is not exactly calculated in cost but it is there.

How big is the problem? It is enormous. Anyway, in physician services the dramatic costs of liability are malpractice insurance, speaking of that specifically, on healthcare cost is a matter of crisis. I will just say that. You have already said it.

Colorado has very good tort reform laws. They have helped keep healthcare costs down in comparison to many other states by limiting liability awards with "caps" on "non-economic" damages such as pain and suffering and other subjective claims that are difficult if not impossible to document.

This is not the case in many other states whose legislatures have refused to pass tort reform laws similar to Colorado and California. For example, in Nevada, malpractice premiums rose to levels where the Las Vegas Hospitals had to close their Emergency Rooms because there were no doctors who could afford the insurance required to staff them. Big time change.

Obstetricians in many parts of the Country are giving up delivering babies because of the cost of malpractice insurance. In some cases the premium was higher than their previous years' gross income so what choice did they have? Surgeons in some areas are refusing to do high-risk procedures. Doctors are leaving practice or moving to other States because of the malpractice climate.

Neurosurgeons, already in short supply, are leaving areas where premiums and claims are notoriously high.

There was a sign at the north end of Mississippi at one time that said, "Please drive carefully. The next neurosurgeon is 500 miles away."

The result is not only are cost of health care increased by high law suit awards and the resultant increased liability insurance premiums, but access to quality health care is dramatically affected.

I have only scratched the surface. Much needs to be done. There are many causes for the alarming increasing costs of healthcare, as we have heard by the previous testimony, in the United States and in other countries, too. It is very hard to control. The contribution of this one can be slowed if not totally controlled by appropriate and prompt tort reform laws as has been shown in California and Colorado. This is one thing we have a little control over.

Federal legislation to establish parameters for tort reform has been passed in the House of Representatives, I have in my records, nine times and the Senate has failed to confirm the wisdom of the House in each and every case. States have been slow to face the

problems through legislation or good legislation has been passed only to be overturned by the courts. The voters in Texas were so frustrated that they passed a Constitutional Amendment to establish caps on non-economic damages with the result of sharp decreases in insurance costs.

Other measures are necessary to approach this ever-worsening problem. Because many regard a malpractice claim as a "Gold Mine" many non-meritorious claims are filed in hopes that a settlement will be made to avoid the cost of fighting a claim. In Colorado over six million dollars a year is spent by one malpractice insurance carrier to fight non-meritorious claims. A non-meritorious claim is one which was either thrown out of court, was dropped by the plaintiff, or was agreed in some way to not be worth pursuing.

Chairman MUSGRAVE. I will ask you to just wrap up now. Thank you.

Dr. CLETCHER. Okay. The Medical Profession feels strongly that a patient who has been injured should be compensated fairly. The fact is that the actual amount the patient receives is so often much less than the actual award because of the legal fees and other costs of obtaining a judgment.

In summary, we are faces with a problem that can be greatly improved. The problem is the significant increase in healthcare costs due to large liability judgments and the attendant increase in insurance premiums across the board for healthcare providers and industry at all levels.

It can be improved by enacting fair and effective tort reform laws in each state or, in their absence, by the federal government; reducing the number of non-meritorious lawsuits by the use of "Blue Ribbon" panels or Healthcare Courts; by placing more healthcare decisions in the hands of the patient and their physician; by the use of Health Savings Accounts and establishing a good doctor/patient relationship with more comfortable insurance environments; and by removing the legal roadblocks that prevent the truly injured patient from receiving fair compensation.

[Dr. Cletcher's testimony may be found in the appendix.]

Chairman MUSGRAVE. Thank you very much.

Deb Tamlin, you are up next. Thank you for being here today.

STATEMENT OF DEB TAMLIN, ZTI GROUP

Ms. TAMLIN. Thank you. Chairman Musgrave, Congressman Shadegg, I want to personally thank you for your work on this. I know both of you have been real committed the last several sessions to pass something and we hope that the Senate will agree one day.

My name is Debbie Tamlin and I am a realtor in Fort Collins and I own my own real estate company. I am speaking on behalf of more than a million members of the National Association of Realtors. NAR is the largest trade association in the United States. We have members that are engaged in every type of real estate profession. I do commercial real estate myself personally. We have a lot of residential members.

I appreciate the opportunity to share thoughts on the challenges that face small businesses and the smallest of the small business, the self-employed in finding affordable health insurance coverage.

Unlike other issues that NAR has testified in the past, NAR's members' interest in this is personal. It is not one for the consumer and a lot of the other issues professionally that we work on. Real estate sales is the prototypical small business. I am a small business person. I have five employees and I do offer healthcare coverage for each of them.

It is tough sometimes to sit down and try to be evenhanded with it when you have older people that require higher expensive insurance as opposed to the young people starting. I try real hard to be evenhanded with how we give out our benefits.

Real estate agents are independent contractors. They are not employees of firms of which they are affiliated but, in fact, usually a firm of one. Our shareholders are our families. We are not large businesses. As a consequence, real estate agents are typically forced into the individual insurance market, a market that is basically a take it or leave it proposition. There is no leverage and there is no negotiation.

Today 28 percent of realtors, more than one in four of our nation's 1.2 million to do have any health insurance. In seven years the percentage of uninsured NAR members more than doubled going from roughly 13 percent of the members in '96 to 28 percent in 2004. By comparison the percentage of the U.S. population without health insurance coverage was estimated to be 15.7 percent in 2004. The percentage of uninsured realtors is almost double that of the nation.

Twenty-eight percent of our membership are individual members. If each of these individuals is uninsured, it is likely that the other 1.6 persons are spouses and children and an average realtor householder also uninsured. Therefore, we could expect that as many as 873,000 members and their dependents are uninsured, as well as all of our employees. I was uninsured for seven years. It is a tough place to be and I thank heaven that I have health insurance.

When asked why they are uninsured 74 percent site the cost. We publicly support and will do what we can wholeheartedly to help you pass the Healthcare Choice Act. Thank you Congressman Shadegg very much. I think we have been there trying to push back in D.C. In fact, the last time I saw Congresswoman Musgrave we were working on that very issue.

Madam Chair, NAR members believe that powers granted to trade organizations should be the equivalent granted to large employers or trade unions when it comes to negotiating for quality and uniform national health plans for the constituents regardless of where they live. As a result, NAR members strongly support the small business plan including House Bill 525, Senate Bill 406, and more recently Senate Bill 1955.

Small business health plans are by no means the silver bullet that will solve the nation's health insurance problems. It is important that we all sit down and work together to have a solution. We are heartened by the fact that this is exactly the approach that Senators Enzi and Nelson have set down and tried to put opponents and proponents together.

This addresses most of the concerns that traditionally have been raised including state regulatory oversight mandates and fiscal in-

solvency. NAR is committed to working to advance what we believe can be very effective insurance delivery systems. If SBHPs are approved, we will be one of the first to be in the discussions with insurers to craft a quality health insurance package for our realtors members nationwide.

Once again, thank you for giving NAR the opportunity and myself a place at the table. Thank you.

Chairman MUSGRAVE. Happy to have you here today.

Now we will hear from Allan Jensen from the Health Underwriters. Welcome to this hearing today.

STATEMENT OF R. ALLAN JENSEN, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Mr. JENSEN. Thank you, ma'am, and Congressman Shadegg. Good afternoon. As a sidebar, Congresswoman Musgrave, I would like to thank you and your staff for entertaining our group in Washington at the end of March. We had a nice chat with your staff. Unfortunately, you weren't there. We were watching you on the TV down on the floor.

Chairman MUSGRAVE. At least I have an excused absence. Thank you.

Mr. JENSEN. Again, my name is Allan Jensen. I am an independent broker of health, life and senior insurance products. In my health insurance practice I specialize in individual and small group insurance sales. I have been a licensed health insurance agent in Colorado for 15 years.

My colleagues and I deal directly on a daily basis with thousands of consumers of health insurance and the carriers that provide those products. In fact, we also deal with providers often in their roles as consumers of health insurance. All together we get to hear and discuss first hand the needs and desires of American consumers probably more than any other organization. We are the integrators and educators within the health insurance industry.

I will bracket my remarks by noting that healthcare is not expensive because of the cost of health insurance, rather it is health insurance that is expensive because of the cost of healthcare, and not coincidentally because of the costs of mandates placed upon these products.

The Colorado State Association and the National Association of Health Underwriters seek to address these questions of cost while also striving to maintain consumer choice and the viability of a vigorous private market of health insurance products.

I will take a page from Mark Hillman's testimony because, as you will see in the written remarks, everything that he said is going to be in there, too, so I will skip down a few pages on the market reform issue.

I will bring up the fact that beginning September 1st as one example of market reform a major national carrier here in Colorado is introducing an entirely new set of plan designs for the small group market very competitively priced to secure major market share. There are a host of other examples.

New and innovative concepts in the design of health insurance products will also help improve competition and buttress the overall strength of the small group marketplace. One such innovation

was proposed in this past Colorado legislative session where a simple two-word modification of existing statute allows carriers to alter the participation and contribution requirements. In less than four months we have seen the introduction of improved choice options from multiple carriers with lower price points.

Vigorous competition, new and creative plan design, and consumer choice are working together to improve and stabilize the small group market. Our association is always welcoming of greater competition and would like nothing better than to see more carriers enter our market. Without such competition, healthcare costs would surely rise more rapidly.

A key element in promoting healthy markets and competition is the availability of easily accessible information regarding price and quality. The lack of good information in these areas plagues the consumers of healthcare. In the last legislative session in Colorado a bill was passed requiring hospitals to post an annual report card.

This is one good step but more needs to be done to make pricing and performance data broadly transparent. Many insurance carriers are voluntarily beginning to post cost data on their websites. Some efforts at the federal level in both Medicare and Medicaid show promise and other proposals before Congress need to be advanced in this regard. This will all play into the business of consumerism.

Regarding Association Health Plans, not all health coverage ideas are good for the market or useful to consumers. NAHU specifically opposes proposals to create Association Health Plans that are exempt from health insurance benefit mandates and state rating laws, or are exempt from fully insured requirements. We are concerned because unregulated AHPs would have a pricing advantage over the fully insured small group markets already operating in the states, thus creating a distorted playing field.

One unintended consequence from unregulated AHPs might well lead to the reduction of choice for consumers by driving fully insured carriers from the market. Two specific areas of concern with AHPs would be the elimination of requirements at the state level for capital reserve requirements as well as claim reserve requirements. NAHU does not have a formal position on H.R. 2355 as our membership is split nationally on the idea of allowing the sale of individual health insurance products across state lines.

This attempt to provide relief for states primarily in the Northeast where individual markets are hampered by both guarantee issue and community ratings doesn't necessarily help in other states. There are a number of significant issues that cannot be overlooked, not the least of which is the state oversight of insurance.

The bill attempts to ensure the integrity of this oversight, but the problem of complaint resolution for people in one state appealing to another state's insurance oversight authorities is highly problematic. Though a particular state might be a good place to domicile for business purposes, could or would that state be willing to oversee consumer complaints from other states in a manner that is as consumer-friendly as in the local model.

In Colorado individual health insurance products are not required to be sold on a guaranteed issue basis and medical under-

writing and exclusion riders are allowed. In tandem with this we have a high-risk insurance pool in the form of CoverColorado to provide guaranteed access to individual health insurance coverage for people who are "uninsurable" in the private marketplace.

Recent improvements passed by this year's legislature allows greater rating flexibility in CoverColorado which should lead to lower rates promising guaranteed coverage to a much larger pool of uninsureds.

Another positive development in the arena of health insurance products has been the advent of Medical Savings Accounts in the late 1990s and now with the improved benefits offered with Health Savings Account qualified plans. These insurance products—

Chairman MUSGRAVE. If you could wrap up, please.

Mr. JENSEN. —are an important product for consumers. I will reiterate what Dr. Cletcher said about medical liability reform. That is kind of a word-for-word conclusion here. We would like to thank you for this opportunity to talk to you today and I will stand to answer any questions you might have. Thanks.

[Mr. Jensen's testimony may be found in the appendix.]

Chairman MUSGRAVE. Thank you. To all the witnesses, all of your testimony will be in the written record if you didn't get to give it all.

We will hear from Gail Snyder now. Thank you for being here.

STATEMENT OF GAIL SNYDER, SNYDER INSURANCE AGENCY

Ms. SNYDER. Thank you so much. Allow me to introduce myself. I am Gail Snyder and I have the pleasure and honor of working for my husband, Bob Snyder, through his farmer's agency as a specialist in life and health insurance primarily working with individuals and small business.

The three areas that I would like to touch on are the Health Savings Accounts, Association Health Plans, and the Healthcare Choice Act. Since the introduction of Health Savings Accounts, HSA's, the health insurance industry has undergone several changes as has the insured community. The industry is seeing a tremendous increase in the number of businesses and individuals purchasing these qualifying high deductible health plans and an increase in the opening and funding of these accounts.

Employers are saving between 20 and 40 percent off their monthly premiums and many are passing some of that savings on to their employees by assisting in funding the employees' accounts. For employers who are already offering health insurance to their employees as a benefit this has become a viable cost containing effort. I commend the creativity and foresight that brought these to the industry. Thanks. It is becoming a very useful tool.

Regarding Association Health Plans, the Association Health Plans that I would like to speak directly to are small associations, something along the size of our local chamber. At first glance they can be appealing. However, once the plan is in place there is a high probability of rapidly increasing costs and diminished participants. Individuals wanting health insurance are typically better served through individual policies where there are fewer mandates in coverage and, therefore, lower premiums.

If these individuals are unable to obtain insurance on their own due to pre-existing medical conditions, they seek alternatives such as Group Insurance. When evaluating the cost of Group Insurance, small business owners oftentimes see the premiums as unaffordable and cry out for an Association Health Plan, under the misconception that there will be lower premiums.

These types of plans need to be entered into with tremendous caution. The benefit Group Insurance has over an Association Health Plan is the risk pool is much larger. There again, I am speaking towards the smaller associations. An insurance carrier can offer a group plan to a state-wide audience of tens of thousands, whereas an Association Health Plan may be offered to only a few hundred. The rates are based upon participation and claims.

A single catastrophic health condition, such as a premature baby, can be tolerated much better at the group level than it can for an Association Health Plan. A single shock claim could raise the Association Health Plan premiums to the degree that participation would rapidly decrease. This leaves an even smaller risk pool behind to bear the cost of healthcare. It becomes a death spiral for this plan.

Any type of national Association Health Plan could create a guaranteed issue coverage similar to the Business Groups of One here in Colorado. It has proven to be disastrous. When Business Groups of One came in, as Mr. Hillman stated, we had 84 carriers. Business Groups of One guaranteed issue we now have 10. It has proven disastrous. Other states that have tried guaranteed issue insurance find that part of the problem here is adverse selection and fraud.

Allow Business Groups of One to purchase Association Health Plan coverage would prove equally problematic increasing the likelihood of plan failure and resulting in significant cost increases for all the state small group market participants.

A potential alternative would be for professional business associations to be considered a "group" such as the local chamber if we use that size as an example if they are considered a group for the purpose of purchasing health insurance. I don't recommend this either, though. The association would then bear the responsibility as an employer rather than an association having all of the liabilities put upon the association which those liabilities could then cause the association itself to default.

Under that evidence there is no specific evidence that states Association Health Plans would have lower premiums. I would not encourage that action. I would also caution, however, that nationwide large corporate insurance plans, such as what you are recommending, could be offered. But what would make them greater as an offering than what the unions or our larger retail chains are offering their employees? What specifics will those plans contain that make them a viable plan?

The last point would be healthcare choice, H.R. 2355. It is my understanding that this legislation is being considered for the purpose of allowing individuals to purchase health insurance across state lines. There are several states that have passed overburdening legislation for the health insurance industry and have caused crisis situations for their respective states.

This legislation has been conceived as a mechanism to bail them out of their own mire. I do not believe this is the solution. We get back to the magic wand. If we could raise that wand and undo the things that have created those crisis in those states, they then can solve their problems. Each of these states needs to recognize the situation they have put themselves into and attempt to reverse those misconceived health insurance initiatives.

Chairman MUSGRAVE. If you could just wrap up, please.

Ms. SNYDER. To every legislator who believes he or she has a new very important mandate to add to the insurance industry, mandates come with a cost and that has been said multiple times. For the consumer this particular legislation has even greater potential problem. In order for it to be successful each insurance carrier must have access to a nationwide network or go back to a reasonable and customary so that you are not seeing someone out of network because your state insurance happens to be through Arkansas while you live in Colorado.

The other issue with this is insurance licensing. In order for me as an insurance agent to sell into a state plan that is not a Colorado state plan, do I then need to be licensed in all 50 states, or does there become a national insurance broker producer licensing system. Thank you so much.

[Ms. Snyder's testimony may be found in the appendix.]

Chairman MUSGRAVE. Thank you very much.

As you can tell, the witnesses here have differing opinions and I think that is very good that we bring our ideas to the table.

Congressman Shadegg, I know you have just been ready to question here so go ahead. You go first.

Mr. SHADEGG. You are going to let me go first.

Chairman MUSGRAVE. Yes.

Mr. SHADEGG. Okay. Well, I will simply start by saying I think you have an extremely well-informed and knowledgeable panel. I appreciate the testimony of all of them. Quite frankly, I am not certain how many questions I have. I may have a series of comments. Let me just go through some that occur to me immediately.

I think Chris Boesch raises a great question. That is, how is it that we decided as a nation that it is the employer's function to provide health insurance or provide healthcare. I have been answering the question for a long time, or looking at the answer to that question for a long time.

Before I give the answer, however, of how we got there, let me talk about how anomalous it is. I would bet there is not a person in this room who is provided by their employer, or if there is there is only one, their auto insurance policy. You don't typically go into your job and say, "I want to apply for a job. Oh, by the way, if I get a job here what are you going to provide me in auto insurance?"

Same is true for homeowners insurance. You don't go to your employer and say, "Now, if I take a job here, how are you going to cover my home?" We have decided that the American people can buy auto insurance on their own. They can buy homeowners insurance on their own. They can buy disability insurance on their own. How is it that we have decided that they cannot buy or should not buy health insurance on their own?

I believe there is consensus on this point. There are disagreements on some of the other issues in healthcare reform but there is consensus on this point. The reason that most health insurance in America is employer based is an historical anomaly. It comes out of War World II. At a point during War World II the federal government stepped in and imposed wage and price controls. They said to all American businesses, "You may not give wage increases and you may not have price increases on your products without going to the federal government and asking for approval."

American business being ingenious as it is, particularly small business, but all American business being entrepreneurial in nature, went to the government and said, "Well, wait a minute. How are we going to attract and retain the best and the brightest in our business? What if we decided instead of giving them wage increases we instead gave them a benefits package?"

The federal government mulled this over and came back and said, "Yes, you may give them benefit packages and you may do that without government approval." Suddenly American business was told, "If you want to give your employees a thousand dollar a month or a thousand dollar a year increase, the government has got to sign off on that. If you want to give them a benefit package (and at this time if was any kind of benefit, but healthcare rapidly became the most attractive benefit in America) you do not have to go to the government for approval to give that benefit package."

The second thing is that employers then immediately went to the IRS and there is an IRS ruling which I can provide to you which answers this question and said, "If we do decide to give our employees $1,000 a year healthcare benefit package, are you going to tax that?" The federal government in an IRS ruling that is still on the books today came back and said, "You know what? We won't tax that. The cost of that benefit package will be an expense to your company deductible as any other expense, but it will not be income to your employee."

It didn't take American business very long to figure out, "Oh, my gosh. If I hand my employee—after World Ward II they could give out wage increases. "If I give them a thousand dollar salary increase, the government is going to tax that and it is going to take at least a third of it." In some instances we all know it is two-thirds of it. "But if I give them $1,000 in healthcare benefits, the government is going to tax zero of it."

Not only did American businesses quickly figure out, "This is a great idea. We will hand out benefits," but American employees figured out and American unions figured out, "If we negotiate for an extra $1,000 for our employees, they will get maybe $700. If we negotiate for an extra $1,000 in healthcare benefits, they will get $1,000 in healthcare benefits." That is how we got to the situation where healthcare in America is the responsibility of employers.

I strongly believe, and there is not time here to go into it, that we need to challenge that concept. We have raised the belief in America that the only appropriate pooling mechanism, and we have had some discussion here about pooling mechanisms and the dangers of having a too small pool or a pool that was created without careful thought of who could get into that pool, and somebody used the phrase "death spiral" which is a term used to describe a

pool that becomes too small and is populated only by the sick and the healthy leave it, we have created this notion that the only pooling mechanism can be employers. I suggest that is something that in this debate we ought to reexamine.

I guess the next point I want to make is I want to go, Mark, to your point about refundable tax credits or about deductibility. It is outrageously unfair in America that we treat big business different than small business. It simply is unjustifiable. You heard some testimony here about people who say, "Yes, there are ideas that would put small business on the same playing field with big business when it comes to health insurance." Association health plans is an idea to do that.

Two witnesses criticized Association Health Plans because they think that might be a mechanism to try to place small businesses on the same playing field as big businesses and those criticisms could be valid. I, for example, agree that moving more regulation of the healthcare market to the federal government, which Association Health Plans does, is a bad idea.

It is an aspect of AHPs I don't happen to like. But it is really unfair to say if you are General Motors or you are Honeywell or you are Intel, you can offer a fantastic plan to your employees no matter where they are in all 50 states. You heard a couple of people say when we do that, we are taking them out from under state regulation. I have a flash. Every big employer who offers healthcare benefits to their employees in Colorado is regulated by the State of Colorado Insurance Commissioner to the extent of zero.

If you work for General Motors in Colorado or Delco or General Electric or you pick any other large national employer and you have a problem with your healthcare plan, don't waste your time driving down to the Colorado Sate Health Commissioner because he will tell you, "It is not my problem." Federal government took this one away a long time ago under a law that I believe you mentioned, or somebody mentioned, ERISA.

But it is simply outrageously unfair to say the big guys get a break, little guys don't. Think about this one. We say as a nation to every American, "You really should be insured." There was a discussion here about, I think it was your comment, Mark, the Northern Colorado Medical Center has a—no, I am sorry. This was the gentleman from the beer industry—has a bad debt ratio of 9.7 percent. You know what? It is not that they are bad at collecting bills. It is that the United States Congress has said to them, "Anybody that shows up in your emergency room gets free healthcare period."

Now, let me see if we understand this. We don't want people to go to the emergency room for free care. We want them to buy health insurance but for everyone in this room who can't pay their employees' health insurance, can't provide healthcare coverage, we say to them, "Here is what a good deal the federal government is going to do for you."

The guy next door, this woman that has just five employees and she gives her employees healthcare, that is paid for with pre-tax dollars. That is, the cost of the healthcare that she gives to her employees is paid out before she pays taxes so you don't pay tax on

that. But anybody here whose employees don't get employer based healthcare, they have to pay it after tax dollars.

That means it is at least a third more expensive. It is outrageously unfair. I personally have a bill called the Patient's Healthcare Choice Act which would go at many of the comments that were made here today.

It is different than the Healthcare Choice Act which goes at an interstate market for healthcare but this instead talks about giving a refundable tax credit to every American to purchase healthcare so we would no longer have the anomalous situation where if you are lucky enough to work for a big employer, your healthcare is paid for with pre-tax dollars.

If you are unlucky enough not to work for an employer who provides you healthcare, you have to use post-tax dollars which need to cost at least a third more. I guess in a way I am just kind of going left to right following through my notes.

Dr. Cletcher, you mentioned a number of things that can deal with the extreme cost of litigation on the system. You talked about the point of non meritorious claims. You did mention that Colorado has passed some good tort reform. One of the reforms I advocate looks at the issue of non meritorious claims. The vast majority, for example, of medical malpractice cases are dismissed outright. Either they are dismissed before they go to jury or the jury finds for the defense making the point that they were non meritorious claims.

Arizona, unfortunately, has not enacted healthcare reform, litigation reform in the healthcare arena, or any other arena because our constitution complicates that and would require a constitutional amendment for us to enact caps or any other reform that would go at litigation cost. Do you know if the State of Colorado looked at the issue of loser pays?

Dr. CLETCHER. Yes, they have. One of the best ways to avoid non meritorious claims is to have a firm doctor/patient relationship. If I have a doctor for 20 years and something adverse happens, usually the doctor says, "Look, this happened. Let's talk about it." The patient will probably not elect to initiate a claim. I think that is what has happened to the system is we don't have that relationship anymore when managed cares organizations and other entities will dictate the choice of physician to a patient.

Corporate insurance is more or less what you would call a captive insurance company for malpractice claims in the State of Colorado. They have looked at loser claims but they have a better program, I think, right now in that anytime an adverse occurrence occurs the physician will notify the insurance company and the insurance company with that physician will contact the patient and try to work out the most comfortable solution for that patient.

In other words, if they are missing work rather than take that penalty which is a non litigated penalty, they will assist them with living expenses and other assistance to work it through. They will readily make a settlement in a claim where there is clear malpractice so it does not enter into that. Even in spite of that we still have $6 million worth of litigation expense to handle non meritorious claims.

This isn't exactly an answer to your question about loser pays. It has been suggested and, I think, Mark, you might know more about that. There have been, I think, bills that have been introduced into legislature that to my knowledge has never gone anywhere. It is kind of considered not fair game. The Lawyers Association don't like that too well. That is basically it. We can go on and on with it but that is it essentially.

California was the one that introduced the first microlaw which is the one that limited the caps on noneconomic damages and things like that and was so successful there that other states have tried to emulate it. Fortunately, Colorado is probably pretty close to next in line on the whole thing.

The tragedy is that a lot of states have enacted some really good laws, or at least in part, trying to solve this problem and then the State Supreme Court will come along and set it aside as being not constitutional in that state. That battle goes on. Well, I won't reiterate it. I have a lot more information on this.

Mr. SHADEGG. Actually, for anybody on the panel, it sounds to me like at least if Colorado has that kind of structure where the insurance company and the doctor then contact the patient who has alleged an injury, it sounds to me like there must be something like an "I'm sorry" provision. Arizona does not have an "I'm sorry" provision. Anybody here have knowledge of what you have on that issue?

Mr. HILLMAN. Colorado in the same year that we closed a couple of loopholes created by our Supreme Court actually passed an "I'm sorry" provision to allow a doctor to have that conversation with the patient and it not be used against him later in a proceeding.

Mr. SHADEGG. I think it makes a lot of sense. I have supported it in Washington. It is kind of anomalous, it seems to me.

I do agree, doctor, that the destruction of the physician/patient relationship, which you have spoken about already, I think does encourage lawsuits as the first mechanism to address a grievance. I think the absence of an "I'm sorry" provision does that as well. Lots of times people if they simply understood that the doctor felt badly about something that may have gone wrong, humans are humans and they are going to make errors, you can go a long way towards solving this problem.

Yet, the tort system, for example, in my state where we have no "I'm sorry" provision makes that near impossible. A doctor can't even think about stepping forward directly or through his lawyer and saying, "We regret that this happened and we are sorry that you are suffering," because that immediately would come into court.

Dr. CLETCHER. As regards to doctor/patient relationship, it is pretty hard to sue somebody that you have known for 10 years and trust. When you don't even know that person, when a patient really has been treated by a doctor that maybe saw him once or twice, never saw him again and can't even remember his name, it is amazing how many people don't remember the name of the doctor that took care of them. It is pretty easy to see somebody like that because they don't really exist. They are just an abstract figure.

Mr. SHADEGG. I don't know what my time limit is but just a quick comment on that point. As you and I have privately dis-

cussed, I personally believe that employer-based healthcare, at least where it is not an indemnity plan, your employer picks the plan and assigns you to the plan, the plan picks the doctor and assigns the doctor to the plan and the doctor you get is not as a result of your choice and on any given day you can be told, "I'm sorry. The doctor you have been going to for the last three years you may no longer go to," I think has done immense damage to the physician/patient relationship and encouraged this kind of litigation.

Dr. CLETCHER. I will be honest with you. That is the key. That is the secret. That is the touchstone that has destroyed the healthcare system in the United States right there.

Mr. SHADEGG. The legislation I have tried to introduce tries to go toward consumer choice and patient choice and put people back in the position where they can pick their own doctor. One of the bills that I introduced that might be of interest to a number of you, somebody on the panel said workers don't appreciate the value of the insurance.

The broader legislation that I introduced called the Patient Healthcare Choice Act would say to all employers in America once a year when you are renewing your insurance policy, or at some point in the calendar year, you would go to your employees and you would say to them, "We are spending this amount on your health insurance," and you base that calculation on their age, their sex, and their geographical location because those are the major factors in the cost of health insurance policy.

You would be obligated to say to the employee, "This is the amount we are spending on your health insurance. You have 90 days to go look for a policy. If you choose, you can take that amount of money and you can go buy your own policy with it and not take our insurance plan out of the company. If you decide after that 90 day expiration period that you can't find a better insurance policy, of course, then you will remain when we renew it in our plan.

One of the advantages I see in that is that lots of employees have no appreciation for how much health insurance cost, how much you are spending on health insurance. A lot of people say to me, "Look, Congressman, in today's health insurance market nobody is going to be able to go out and get a better policy than they can get through their employer."

I don't personally believe that is true. I believe that if we gave them that possibility many of them would find more attractive policies. Let us assume it is true. Can you imagine if all your employees came back to you at the end of that period and said, "My gosh, you are giving me the greatest deal in the world. I couldn't get anything close to it."

I don't know how we are doing on time and I don't want to abuse my privileges. Let me just conclude with a couple of quick comments. I would be happy to discuss in detail some of the issues raised here about the Healthcare Choice Act. A lot of people do call it interstate health insurance purchase and it really is not. That is a mischaracterization of the policy. The policy would be filed in the state where it is to be sold.

It does under the bill have to be governed by a great deal of the provisions of that state's law. For example, the consumer fraud pro-

tections of the Colorado policy would apply in whole exactly as they are. The Colorado law would apply to the policy no matter where the policy had been originally qualified. The notion that those consumer protection laws wouldn't apply is incorrect.

In addition, the remedy, just to answer another question that was raised, the remedy is with the insurance commissioner of the state where the consumer lives. Let us say the Goodwill Insurance Company filed a policy in, we will say, Illinois and qualified it under Illinois law, they then bring it to Colorado and they have to file it with the Colorado insurance commissioner.

The Colorado insurance commissioner gets to look at it and make sure that it satisfies those pieces of Colorado law it has to satisfy and it satisfies the Illinois law. Then a consumer buys that policy. They buy it here in Colorado. The answer to the last question, they can only buy it from a licensed Colorado insurance salesman so there would be no national licensing of insurance salesmen.

You would sell that policy in the state under Colorado licensing practices and continue to be governed by Colorado licensing practices. Then the regulation if there were a problem with the policy would be by the Colorado insurance commissioner. It is, in fact, a completely new idea. It is a way to try to bridge that point that was brought up a little bit earlier about, "Do you want federal regulation of health insurance or do you want state regulation of health insurance?"

In every respect where we could we tried to leave state regulation in place, in part because of the point that both of you make about association health plans. ERISA took all this large employer health insurance out from under. People say, "Oh, my gosh, Congressman. If Colorado had a benefit mandate for acupuncture and an Illinois qualified policy were brought here and sold and it didn't offer acupuncture, then you would be saying to people in Colorado that they could buy a policy that didn't cover acupuncture and they would be getting out from under a Colorado state mandate."

I have a flash for them. Everybody that gets their health insurance from a large employer, General Electric, General Motors, governed by ERISA, no Colorado benefit mandate is covered under those policies. I guess I will conclude, Madam Chairman, by saying that I actually share Mark's biggest concern about the concept of allowing an insurance policy to be brought here and sold here and that is once you let the federal government into like you let the federal government into ERISA, there is the danger that sudden wheels start mucking around and saying, "We didn't cover as a mandated benefit X when we first passed it back in 2006 but now we think we really should have a federal benefit mandate for whatever that is.

Chairman MUSGRAVE. Thank you very much. I would just like to say to Debbie Tamlin, you kind of put a face on realtors that most people don't think about. I don't want to show anything preferential here but, quite frankly, they see a Remax sign or Century 21 and I don't think—I believe you said you had five employees. They don't think about a small business owner facing the obstacle of trying to come up with enough money to provide health insurance for your employees. Could you elaborate on that a little how it affects you when you are out there as a small business owner?

Ms. TAMLIN. I compete for my employees with HP and Bush and these guys at Fort Collins so the larger companies can provide benefits as a package. To get the quality employees that I want to work with me, I want to be on a level playing field with the larger employers so I work real hard to do that. Most all of us are commission based. I took six weeks off from my company when I had my neck fused and that meant there was six weeks nobody was producing income from my company.

I had put the surgery off for 11 years, a long time until I couldn't do it any longer because you are shutting down the income producing function for your company. It is a huge thing because my company is commission based. The income is not regular and, yet, I have payroll to meet and I have benefit packages that I want to compete with so I have the quality real estate company that I do have. It is important.

Chairman MUSGRAVE. Thank you.

Dr. Cletcher, I recently talked to other orthopedic surgeons and, you know, now you hear a lot about hip replacements and knee replacements. When we talk about these prosthetic devices whether you have anchors in a shoulder when you have rotator cup surgery or knee replacement, I don't think a lot of people think about the liability associated just even with the prothesis much less your actions as a surgeon. Could you speak about that a little bit?

Dr. CLETCHER. Let me put it very simply. Suppose I come up with a new design for a hip replacement and it works pretty good. Then somewhere down the line after having put in about 4,000 or 5,000 of them, they find that there is a design defect which after five years has caused several of these to fail, maybe as many as 20 percent or 25 percent. Now, these devices are scrutinized to the ultimate. They are x-rayed.

They are put under stress. They are put in testing machines. There is an enormous amount of effort that goes into developing these devices to try to prevent this very thing from happening. Say if you put in 6,000 of them and 30 percent of them have failure rates of some degree may not be entirely due to the prothesis itself. It may be to some other problem that has arisen that has shown up in this number of cases.

Not only is the physician sued, the hospital is sued, but the manufacturer is sued with settlements from the manufacturer maybe in terms of let's say many, many thousands of dollars. I am not going to say a million dollars because in some states that is exactly what happens, $1, $2, $5, $10 million and that sort of thing. Add that times 2,000, what have you got in claims that can rise just from this one thing?

This is what I say about medical devices. Pacemakers, another very, very precarious market where there has to be a lot of insurance against the unforeseen happenings. Remember in malpractice and in device failure it may not be through anybody's fault other than the fact that there is a statistical rate of failure in almost any medical procedure or intervention.

If those are classified due to negligence or to some manufacturing defect, that is one thing, but many times awards are given in these cases because the jury feels sorry for the person who has been unfortunate enough to have one of these unforeseen unavoid-

able events. This is just another bunch of beans that are poured in the pot and have to be mixed up, you know, before you can get it all done.

Chairman MUSGRAVE. Well, Mr. Shadegg, do you have any closing remarks that you would like to make?

Mr. SHADEGG. Just, again, I think this is an extremely knowledgeable panel. You could wish that everyone's comments were covered because I think it was a very good debate. All Americans need to learn these issues. I think it was a very informed debate and a good discussion of how we address these concerns. I am very impressed with the panel and with your work to try to address this problem which confronts every American and every American small business.

Chairman MUSGRAVE. Yes. We know the small business is where most job creation takes place. Having been a small business owner myself, I can identify with many of these issues. I believe that Congress can come up with solutions to these problems. My main concern is that we better come up with them quickly with the input of people around the nation before we move to a nationalized healthcare system.

Many of the problems that we talk about, patient choice, and I really believe, Dr. Cletcher, it is a call on your life when you go into medicine. We were even talking about your father earlier today. I said did your father burn out and you said no, you really don't get burned out but you do get tired. I want doctors to be able to practice medicine and I want patients to have choices. All the problems that we have now in that area I believe would only be magnified many times over if we went to a national system.

Go ahead.

Mr. SHADEGG. I did think of one last thought, a point I meant to make earlier. The media would have you believe and the trial lawyers would have you believe that the rule in America where each side bears its own cost regardless of the outcome of the lawsuit so you can bring a lawsuit, you can sue somebody.

The lawsuit can prove to have been meritless, yet the defendant, who has spent a lot of money, maybe the producer of one of those manufacturing devices or a doctor defending themselves against the meritless claim have to pay their own cost and, therefore, there is the ability to extort a settlement. The Trial Lawyers Association would have you believe that the American rule is the rule in most of the world.

The English have this notion of loser pay. I think most American consumers don't know that is wrong. The reality is almost the entire world has the concept of lower pay and the provision that each side must bear its own cost is the exception around the world.

The other point I want to make is a lot of us are looking at losing lawyer pays. We all know lawyers share the recovery. The point was paid earlier lots of time there is a large recovery but the injured patient doesn't get near compensated because so much went away in attorney's fees. I think we should be looking at and a number of us are talking about it in Washington. Not just loser pays but more importantly a losing lawyer pays.

Nobody wants to punish the genuinely injured for bringing a claim. If you have a lawyer who consistently brings meritless

claims to extort settlements, there has to be a remedy to that. I have talked to some very, very good tort lawyers who say, "Those of us that are good at this won't take a meritless case and we have no problem with that kind of remedy."

Chairman MUSGRAVE. Good. That would be kind of a relief, I believe, when we bash lawyers all the time to hear that some would even go for that. I thank you for your testimony today. I appreciate the diverse opinions that we have heard from our panel but all very well founded. I wish we had more time. I wish we could talk to orthopedic surgeons and talk about how when they—I don't know, would $18,000 be right for a knee replacement or something?

Dr. CLETCHER. Are you talking about my knee replacement?

Chairman MUSGRAVE. I didn't know you had a knee replacement.

Dr. CLETCHER. Oh, I do, yes. $40,000 is probably right at the actual cost factors. Managed care will bargain it down to probably half that. Of course, the hospital is working on a very thin margin. Medicare works on a different scale and so their reimbursement would be much less than the actual cost if you went out and bought one yourself.

Chairman MUSGRAVE. It is amazing when you think about probably what the cost of the prothesis and all of the other factors figured in, I guess, what the doctor would actually earn performing one of those. Some on the panel have mentioned, you know, why health insurance is so high. It is because our healthcare is expensive. Also we would be remiss today if we didn't say that it is expensive because it is the best healthcare in the world.

I can see the doctor just has to say something. Go ahead.

Dr. CLETCHER. I do because you talk about what the doctor gets out of it. I can tell you it is about a third of about what the prothesis cost.

Chairman MUSGRAVE. See, those kinds of things would be important for the American public to know. We need to know what our healthcare cost and have that broken down so people can have an understanding of why premiums are what they are. Of course, we in Congress will do what we can to address these issues. Thank you for being here with us today. I appreciate each and every one of you.

Again, thank you Congressman Shadegg.

Mr. SHADEGG. Thank you.

Chairman MUSGRAVE. I would also like to thank the staff that worked on this, Joe Hartz, Small Business Committee, and Kristen Glenn from my staff. We appreciate you. We couldn't do it without you. Thank you. The meeting is adjourned.

[At 2:50 p.m. the Subcommittee was adjourned.]

Opening Statement
Marilyn Musgrave, Chairman
Subcommittee on Workforce, Empowerment, & Government Programs
Healthcare and Small Business—Real Options for Colorado Businesses

- Good afternoon, this hearing of the Subcommittee on Workforce, Empowerment and Government Programs will come to order.

- Thank you all for being here as we examine health care choices for American small businesses, their employees, and working families.

- Before we begin, I would like to thank my good friend, Congressman John Shadegg, for making the trip up from Arizona to be here with us today.

- I consider John to be a dear friend and respected colleague and it is a great honor to host him here in Loveland.

- John was first elected in 1994 and quickly established a reputation in Congress as a leading advocate for reduced government spending, federal tax relief, and the re-establishment of state and individual rights and has proven himself to be a leader on health care issues.

- From 2000 to 2002, John was chairman of the Republican Study Committee (RSC), the largest conservative organization in the House of Representatives. Under his leadership, the organization grew from 40 to more than 70 members, and became the most influential and respected force in the U.S. House shaping conservative policy for the country.

- In 2005, John was elected by his peers to serve as Chairman of the House Republican Policy Committee, the fifth-ranking position in the House Leadership, from 2005 to 2006. At the time, he was the only member of the Republican Class of 1994 serving in the House Leadership.

- So again, thank you, John, for taking time out of what I know to be a very hectic schedule to spend some time here with my constituents.

- All Americans deserve reliable, high quality, and reasonably priced health care that will be there when they need it.

- One of the most stressing statistics we see each year is the rising number of Americans who live without health insurance, currently estimated at roughly 45 million people.

- Of those without health insurance, about 60 percent are small business owners, employees of small businesses, and their families.

- As health care costs continue to rise, fewer employers and working families will be able to afford coverage.

- Clearly, we in Congress must look at this pressing problem and find solutions that will create an environment so those that need health insurance can not only find the coverage they need, but also afford it.

- We need to be working toward a health care delivery method that works best, not just what we've always done. A simple look at the current health care landscape shows that the system is not working.

- Our focus today will be on four proposals that this Congress has begun work on to help Americans get the coverage they need, at a price they can afford.

- These proposals are the establishment of Association Health Plans, or AHPs, increasing the availability, use, and ease of Health Savings Accounts or HSAs, reforming the medical liability system, and examining Congressman John Shadegg's common-sense legislation, H.R. 2355, the "Health Care Choice Act."

- On July 26, 2005, the House of Representatives passed H.R. 525, the "Small Business Health Fairness Act of 2005,"—legislation that would establish federally regulated association health plans, with a strong bipartisan vote.

- This was the seventh time the House has passed such legislation. I am confident, however, that real progress on this legislation will be made on the other side of Capitol Hill this year.

- AHPs would allow small businesses to band together across state lines, through their membership in an association, to purchase more affordable health insurance.

- Unions and large corporations already have this ability and it makes sense to me that small businesses should as well.

- Health Savings Accounts are a new way that people can pay for medical expenses not covered by insurance or other reimbursements.

- Eligible individuals can establish and fund these accounts when they have a qualifying high deductible health plan and no other health insurance, with some exceptions.

- The accounts have significant tax advantages:
    - Contributions are deductible,
    - Withdrawals used for medical expenses are not taxed,
    - Account earnings are tax-exempt, and,
    - Unused balances may accumulate without limit.
- President Bush has proposed several improvements to HSAs, such as allowing Americans who purchase HSA-qualified insurance policies on their own to have the same tax advantages as people who obtain insurance through their employers and eliminating all taxes on out-of-pocket spending through HSAs.

- An additional area Congress and the President have worked on together is tort reform for the medical community.
- America's patients are losing access to care because the nation's out-of-control legal system is forcing physicians in some areas of the country to retire early, relocate or give up performing high-risk medical procedures.
- There are now 21 states in a full-blown medical liability crisis -- up from 12 in 2002.
- In crisis states, patients continue to lose access to care. In some states, obstetricians and rural family physicians no longer deliver babies. Meanwhile, high-risk specialists no longer provide trauma care or perform complicated surgical procedures.
- Excessive litigation and high medical malpractice rates have added to employers' health care costs and spurred some providers to "err on the side of caution" that comes at the expense of both health plan dollars and patients receiving unnecessary service.
- This issue isn't just about physicians -- its effects cut across the health care sector.
- Hospitals need physicians to admit patients. Companies that manufacture medical devices and pharmaceuticals need physicians to use and prescribe their products.
- Similar to the AHP legislation, the House passed H.R. 5, the "Help Efficient, Accessible, Low-cost, Timely Healthcare or 'HEALTH' Act of 2005," on July 28, 2005. The Senate is continuing its debate on this critical legislation.

- Yet another proposal to help Americans find and purchase affordable health insurance is legislation introduced by Congressman Shadegg—H.R. 2355, the "Health Care Choice Act of 2005."

- Under this legislation, consumers would no longer be limited to purchasing policies dictated by their state's regulations and mandated benefits. Instead, they could decide among a variety of insurance policies qualified in one state but offered for sale in multiple states.

- As we all know, there is no one solution to a problem as complicated and complex as 45 million Americans without health insurance.

- Small business employers and employees are in critical need of new ways to increase health insurance coverage, and the proposals examined today are responsive solutions to this problem.

- I am very eager to get to today's testimony so please let me say thank you to our witnesses today, but before we begin, I would like to yield to the Gentleman from Arizona, Mr. Shadegg.

"Healthcare and Small Business – Real Options for Colorado Businesses"

Testimony of Matthew Fries, Professional Document Management, Fort Collins, Colorado

Good afternoon Chairwoman Musgrave. It's a pleasure to see you . Welcome to Northern Colorado Congressmen Shadegg and Beauprez. Thank you for holding this hearing and for your leadership to find ways to make health care coverage affordable to small businesses.

My name is Matt Fries, and I am the owner of Professional Document Management located in Fort Collins. My company is in the paper and electronic records Storage and destruction business, and we employ 13 people – 10 full-time and 3 part-time.

Like most small, independent business people, I don't typically look to Washington, DC to solve my problems. Most of us generally operate from the point of view that less government is the best government. And when it comes to affordable health care, government provided health care known as universal care is absolutely **not** the answer.

Yet, the current health care coverage system isn't working all that well, especially for small businesses. My company is pretty typical. The people employed at PDM work very hard and do a great job. They care about our customers and serve them well and for their success, they deserve to have access to first rate health and medical care when they need it.

However, due to the high cost of health insurance premiums, that is extremely difficult for me, if not financially impossible. Currently, we are unable to provide any level of health care insurance for our employees.

There is a direct relationship between the increase in health care and the cost of health care coverage. New medical technologies and new procedures can lead to increases; however, from where I sit there appear to be two major cost-drivers. One is litigation and the other is state mandates.

Because my business serves the medical community, I know a lot of physicians, and they struggle with crushing malpractice insurance rates. Excessive litigation and consequent high medical malpractice insurance

rates cost all of us. Caps on non-economic damages and punitive damages would go a long way to stem rising costs. This is beyond the scope of HR 2355 but deserves your further attention.

Regarding mandates, they are a major cost factor. For decades states have micromanaged the health insurance industry. State legislators require insurance companies or health plans to cover specific services and by doing so they drive up costs for all of us. The worst offender is Minnesota with over 60 mandates; we're fortunate in Colorado to "only" have 19. According to the Council for Affordable Health Insurance, state mandates add between 20 and 50 percent to the cost of health insurance.

This leads to another cost-driver: lack of competition. Price and competition are inextricably tied together. A few large insurance companies dominate the state markets meaning that there is very little real competition in the healthcare insurance coverage marketplace. Where little competition exists in any industry, there is no incentive to keep prices down. I think H.R. 2355 could have the effect of creating a national health insurance market. New competition will drive down costs.

Another issue is lack of flexibility in the health insurance marketplace. Even in my small company employee needs vary widely. The younger employees tend not to care much about health and medical insurance, while middle-aged and older workers do. It's difficult for us to qualify as a 'group' when the young workers don't want to pay to participate in an expensive one-size-fits-all plan with features they don't want. Also, consumer-driven options like Health Savings Accounts, while a huge step in the right direction, need to be detached from employer-provided policies. HSA purchasers should be allowed to purchase any type of health plan and get a tax credit for doing so.

The concept in H.R. 2355 concerning 'small business health plans' is excellent. By allowing small employers to purchase coverage through bona-fide associations, small guys like me will have the same advantages that unions and big employers have. By banding together, small businesses will realize economies of scale, increased bargaining power, savings from administrative efficiencies due to having just one set of rules, flexibility in the design of the coverage and increased competition in the health insurance markets. Small firms and their employees will see lower insurance premiums as risks are spread across a larger pool of people. Small Business Health Plans would give the little guys the same preemption from costly state

mandates now enjoyed by the big guys under the Employee Retirement Income Security Act (ERISA).

I'm convinced that fostering interstate commerce in the health insurance market will increase competition and improve consumer choices just like interstate banking has done.

In summary, small employers like me want:

- to provide health insurance to our employees without the cost and inflexibility of expensive state mandates;
- to encourage further development of consumer-driven health plans like Health Savings Accounts, but to be truly useful HSA purchasers need to have the tax advantage to using them with any kind of health insurance, not just those provided through employers;
- see choices for our employees in terms of coverage they want rather than being forced to buy one-sized-fits-all coverage. Currently, because small firms must buy in a statewide market, we have very limited and expensive choices.
- see true competition in the health insurance industry through creation of a nationwide marketplace;
- see medical malpractice reforms that cap non-economic damages;
- avoid adoption of a system of government provided health care otherwise known as universal health care;
- drive down our costs by pooling our risks on a large scale.

In closing, as a small employer, as stated earler, I don't look to Washington, DC to solve my problems. I don't look to you for handouts. Congress can help, however, by improving the health care market. H.R 2355 is a big step in the right direction. Thank you again for your leadership on this issue and for listening to my testimony.

The Colorado Experience in Health Care Market Reforms
By Mark Hillman

Testimony to
United States House of Representatives
Committee on Small Business
Subcommittee on Workforce, Empowerment,
and Government Programs

It has been said that insanity is doing the same thing over and over again and expecting different results. That maxim could certainly apply to attempts by lawmakers and regulators to "fix" the health insurance market.

If I could wave a magic wand and compel Congress do absolutely anything to the health insurance market, I would simply undo everything Congress has done to the health insurance market.

In fact, apart from licensing insurers to require financial stability, even most state level regulations simply replace old problems in the marketplace with well-intended but politically-driven marketplace distortions. These distortions replace old problems that could be affected and corrected by the choices of millions of consumers and erect political obstacles that are exceedingly difficult to correct.

Colorado's small group market (SGM) for health insurance has been struggling for many years. In 1994, 84 carriers offered small group coverage in Colorado. Today, 10 carriers constitute 96 percent of the SGM.

From 2000 to 2005, the number of lives covered in the SGM declined from 538,000 to 358,000 and the number of employer groups enrolled in small group plans fell from 70,000 to 46,000.

Much of this decline finds its roots in so-called "reforms" of the past:

1. Community rating. Prior to enactment of "community rating" in 1994, premiums were directly related to the health of each consumer.

Legislators enacted community rating in order to protect small business from wildly fluctuating premiums and to keep insurance affordable for consumers with pre-existing health problems. Unfortunately, this replaced wildly-fluctuating costs with rapidly-increasing costs and

disproportionately shifted costs to healthy consumers, causing many of them to simply leave the market.

Look at it this way: You and I go to lunch together everyday. Both of us pay $10 for lunch, but everyday, I get an $18 steak and you get a $2 cheese sandwich. How long are you going to subsidize my steak and be satisfied with your cheese sandwich?

That's the predicament which community rating imposes upon healthy consumers.

And it gets worse, because when healthy consumers leave the market, the high-risk consumers who remain now must bear an even higher cost.

In 2003, Colorado took a modest step toward restoring market based premiums by allowing insurers to offer discounts of up to 25 percent to employer groups, thereby making premiums more affordable for health groups. As the sponsor of that legislation, I will tell you that we need to give insurance carriers even greater flexibility to compete for consumers' business and to attract healthy groups back into the market.

2. Guaranteed issue. Congress compounded the problems created by state-level community rating by mandating "guaranteed issue" of policies to anyone whose employer provides group health insurance.

The rationale for this policy sounded reasonable: no one should be denied insurance coverage because of pre-existing health conditions that would otherwise make them difficult to insure.

The distortion this created is that employees can now decide to forego health insurance coverage until they actually need health care. For young people who tend to be healthy but pay a disproportionately expensive premium under "community rating," this decision makes perfect economic sense – although it's disastrous for the SGM.

By giving healthy consumers every incentive to drop insurance coverage, guaranteed issue laws actually made the pool of those who remain insured less healthy and, therefore, more expensive to insure.

3. Mandated coverage. Everyone who purchases health insurance through the small group market in Colorado is required to pay for 17 mandated coverages, regardless of whether they want or need them.

For example, everyone is required by law to purchase pregnancy and maternity coverage - that's *everyone*, men, women who plan to not have children, and women who are beyond child-bearing age. Incidentally, the pregnancy and maternity coverage – for an ordinary pregnancy with no complications – is now mandated by federal case law, so consumers cannot choose to pay for this out of pocket even if they want to.

This illustrates perhaps the biggest problem with mandated coverage. Most mandates require coverage for things like prostate or breast examinations. From a preventative standpoint, those precautions are certainly wise. However, the purpose of insurance is not to be a compulsory savings plan for medical expenses that can be anticipated. The purpose of insurance is to share the risk for "insurable events" – costs that are unanticipated, unavoidable and difficult or impossible to budget.

Examinations, for example, do not fit the definition of an insurable event. If the real cost of such an examination is $100, mandating that it be covered through insurance is actually mandating that consumers pay the cost plus an administrative fee to the insurance company for collecting that $100 in installments and then paying the provider for the service.

Colorado law mandates virtually the best coverage money can buy. However, the best insurance money can buy is no good if you can't afford it.

As part of our 2003 market-based reforms, we gave consumers one additional choice to purchase a "mandate lite" policy that exempts six of those 17 coverages.

Repealing – or even exempting – mandates is a challenge because the special interests who lobbied to institute those mandates know that, unless they can force everyone to share the cost of their special coverage, they probably cannot afford to purchase that coverage on their own.

So, what can Congress do to actually help consumers and restore a function marketplace for health insurance? Here are a few suggestions:

1. Make health insurance premiums fully tax deductible for everyone. Most business owners or managers do not want to be in the health insurance business. They do not want to make decisions about their employees'

coverage. The only reason they do that today is because of the uneven treatment of insurance premiums by the tax code.

If employers simply add $1,000 a month to each employee's paycheck, the employee pays Social Security, Medicare and income tax on that $1,000 – even if he/she uses the full $1,000 to pay the insurance premium.

On the other hand, if the employer pays the $1,000 insurance premium for the employee, it's fully deductible to the employer.

This is manipulative – not to mention economically insane – because it removes the ability to make choices about cost and coverage from the very people to whom the market should respond.

2. Authorize a refundable tax credit for health insurance premiums. If Congress truly wants to reduce the number of uninsured, perhaps the best way to do that is to empower the low-income uninsured to be health insurance shoppers. One way to do this is to offer them a refundable tax credit large enough to cover, say, two-thirds of the cost of a basic health insurance policy.

3. Leave the regulation of health insurance to the states. Neither Congress nor state legislatures has been particularly successful at "reforming" the health insurance market. The spiraling cost of health insurance and the deterioration of the small group market in most states is evidence of this failure.

That said, in our federalist system, states must be free to learn from their own mistakes and correct them. Today, when state legislatures do finally recognize their own mistakes and attempt to correct them, too often they encounter federal laws or court cases that entangle them further in a top-heavy, regulation-driven "market" that gives consumers little ability to select coverage that reflects their needs and their pocketbook.

Although I am intrigued by prospect Congressional legislation to allow consumers to purchase health insurance from licensed carriers in *any* state, my lingering concern is that Congress will be unable to resist the temptation to meddle in this new national market and will instead begin to implement costly mandates and burdensome regulations at

the national level, once again denying consumers the ability to make choices in a truly competitive free market.

Testimony of John O. Cletcher M.D. before:

Subcommittee on Workforce, Empowerment and Government programs of the Committee on Small Business of the United States House of Representatives.

August 10, 2006, Loveland Colorado

The issue of Medical Liability Reform and its relationship to the increased cost of health care will be discussed.

It is a well-documented fact that the cost of medical liability insurance has risen exponentially in he past 20 years to a level of crisis today. This is largely because of the increased number of claims filed, regardless of their merit, and the astronomical increase in the dollar awards given in successfully prosecuted cases. Multi million dollar awards are commonplace in many parts of the Country.

This problem has dramatically increased the cost of health care at all levels. Hospitals, Doctors, Ambulance services, manufacturers of Medical Devices et cetera are affected. Any entity having to do with health care has seen unprecedented increases in Insurance costs due to liability claims.

Who pays for this? Ultimately it is YOU the patient. We pay more for the care, the services, the materials that we receive and the health insurance that we must buy. The employer pays more for health insurance for his employees with money that could have been used to pay higher wages to those employees. Many small businesses can no longer afford these increased costs.

How big is the problem? Enormous!

I will confine my remarks to the area of physician services. The dramatic effect that the cost of liability (malpractice) insurance has had on the cost of health care is only a part of the problem and in fact may be the less important part. I am retired but in my last few years in practice my malpractice insurance cost one out of every ten dollars I charged. Consider this in the light of the fact that in almost fifty years of practice I was never even sued! Yet I, like all my colleagues, could not risk my professional security and the security of my family by not being insured. Consider also that Colorado has one of the best liability laws in the Country

Colorado's tort reform laws have kept health care costs down in comparison to many other States by limiting liability awards with "caps" on what are called "non-economic" damages such as pain and suffering and other subjective claims that are difficult if not impossible to document.

This is not the case in many other States whose legislatures have refused to pass tort reform laws similar to Colorado and California. For example, in Nevada, malpractice premiums rose to levels where the Las Vegas Hospitals had to close their Emergency Rooms because there were no Doctors who could afford the insurance required to staff them.

Obstetricians in many parts of the Country are giving up delivering babies because of the cost of malpractice insurance. In some cases the premium was higher than their last years' income. Surgeons in some areas are refusing to do high-risk procedures. Doctors are leaving practice or moving to other States because of the malpractice climate. Neuro surgeons, already in short supply, are leaving areas where premiums and claims are notoriously high.

The result is: Not only are cost of health care increased by high law suit awards and the resultant increased liability insurance premiums, but access to quality health care is affected dramatically also!

I have only scratched the surface. Much needs to be done. There are many causes for the alarming increasing costs of health care in the United States (and in other countries) that are very hard to control, but the contribution of this one can be slowed if not totally controlled by appropriate and prompt tort reform laws as has been shown in California and Colorado.

Federal legislation to establish parameters for tort reform has been passed in the House of Representatives NINE times but the Senate has failed to confirm the wisdom of the House. States have been slow to face the problems through legislation or good legislation has been passed only to be overturned by the courts. The voters in Texas passed a Constitutional Amendment to establish caps on non-economic damages with the result of sharp decreases in insurance costs.

Other measures are necessary to approach this ever-worsening problem. Because many regard a malpractice claim as a "Gold Mine" many frivolous or non-meritorious claims are filed in hopes that a settlement will be made to avoid the cost of fighting a claim. In Colorado over six million dollars a year is spent by one malpractice insurance carrier to fight non-meritorious claims. With the increase in claims filed there has been NO increase in the percentage of claims that are ultimately judged to be valid.

The Medical Profession feels strongly that a patient who has been injured should be compensated fairly. The fact is that the actual amount the patient receives is so often much less than the actual award because of the legal fees and other costs of obtaining a judgment.

In summary, we are faced with problem that can be greatly improved. The problem is the significant increase in healthcare costs due to large liability judgments and the attendant increase in insurance premiums across the board for health care providers and industry at all levels and more importantly the decrease in access to care that has occurred. Both can be greatly improved by:

Enacting fair and effective tort reform laws in each State, or by the Federal Government

Reducing the number of frivolous or non-meritorious law suits by the use of "Blue Ribbon" panels or Health Care Courts.

By placing more health care decisions in the hands of the patient and their physician By the use of Health Savings Accounts and re-establishing good Doctor Patient Relationships with more comfortable insurance environments.

By removing the legal roadblocks that prevent the truly injured patient from receiving fair compensation

Respectfully submitted,

John O. Cletcher, M.D.

Thank you Chairman Manzullo and Congresswoman Musgrave. I truly appreciate this opportunity to speak to you today about a number of health policy ideas under consideration by the United States Congress. My name is Allan Jensen and I have been a licensed health insurance agent for 15 years. As an active agent and member of the National Association of Health Underwriters (NAHU), I see on a daily basis how much the cost of health insurance coverage is impacting our nation's employers and economic growth. My association represents more than 20,000 health insurance producers and employee benefit specialists nationally and our two principle public policy goals are to reduce the number of uninsured Americans through private health insurance market solutions, and to make sure that state health insurance markets are a vibrant and competitive as possible, so that Americans have as many affordable and accessible private health insurance option available to them as possible.

Market Reforms and Association Health Plans

For almost 10 years, the Colorado small group health insurance market experienced an exodus of carriers, and in NAHU's view the problem could be traced primarily to two significant factors—the use of modified community rating for products sold in that market and the existence of one-life employer groups. Carriers in Colorado only were allowed to adjust rates based on the limited factors of age, geographic location and family composition. As such, carriers in this market had no means of underwriting products based on health status, which caused rates in the state to skyrocket.

Furthermore, the Colorado small group market is plagued by adverse selection. This is due in part to the fact that the state allows business groups of one to purchase guaranteed issue group coverage. The volume of claims associated with one-life groups is significantly higher than with larger groups where there is more spreading of risk. Furthermore, one-life groups in Colorado tend to purchase coverage on an episodic basis, with the average contract length being only nine months. Other factors contributing to adverse selection in the small employer market are ironically the state's competitive individual market and unique state laws that make it relatively easy for even very small healthy groups to self-fund, and therefore qualify for exemption from state mandates as rating laws, as provided by ERISA.

The end result of all of these problems is that in 1994, before rate reforms were instituted in Colorado, 83 carriers marketed health insurance in the state. However, at the end of the 2003 legislative session, Colorado lawmakers took an important step towards improving their state's small group health insurance market. Legislation was enacted that, among other things, allows health insurers to vary small group market rates based on health status, smoking status, claims experience and industry classification. Beginning September 1, 2003 small group premiums may be discounted below the indexed rate by up to 15 percent based on those criteria, and effective September 30, 2004, the rates may vary by up to 10 percent above the index rate and 25 percent below it based on the criteria. The reform measure does not address the problem of one-life groups in the state, but it will allow small group carriers to more accurately assess risk and price products more appropriately.

Since the reforms have been implemented, it has been my experience, which is supplemented by other anecdotal reports from other local NAHU members who sell small group health plans to employers, that more groups have received discounts than increases. Our membership also reports that the market has become more competitive, with the major carriers competing harder for business and the market share of the dominant carrier decreasing.

Some individuals feel that the creation of Association Health Plans (AHPs) at the federal level will help improve small-employer access to health insurance. However, NAHU opposes proposals to create Association Health Plans that are exempt from health insurance benefit mandates and state rating laws. We are concerned that such AHPs would have a pricing advantage over the fully insured small group health insurance markets already operating in the states, thus creating an unlevel playing field. This pricing advantage could have a negative impact on reforms already passed at the state level and existing small employer markets.

NAHU is also concerned about AHP proposals that would make coverage available to one-person groups on a guaranteed-issue basis. Allowing business groups of one to purchase guaranteed-issue group coverage has proven disastrous to small-group markets in the states that have tried it, due to problems with both adverse selection and fraud, as we know first-hand in Colorado. Allowing one-person groups to purchase AHP coverage will prove equally problematic, increasing the likelihood of plan failure and resulting in significant cost increases for all state small group market participants.

H.R. 2355 Health Care Choice Act of 2005

NAHU does not have a formal position on H.R. 2355, as our membership is split nationally on the idea of allowing the sale of individual market health insurance products across state lines. The attempt here is to provide relief for the states primarily in the Northeast where individual markets are primarily both guarantee issue and community rated; it doesn't necessarily help in other states. There are a number of issues not the least of which is the state oversight of insurance. The bill attempts to ensure the integrity of this oversight, but the problem of complaint resolution for people in one state appealing to another state that has responsibilities to consumer in their own state become dicey. Though states such as Delaware for example, might be a good place to domicile for purposes of creating a "home base" for the insurance, it is not known whether the state is willing or able to oversee consumer complaints from other states.

In Colorado, individual health insurance products are not required to be sold on a guarantee issue basis and medical underwriting and elimination riders are allowed without restriction. Also, the state has a high-risk health insurance pool to provide access to individual health insurance coverage to people who might in other states be considered "uninsurable" in the individual market because they have a serious or chronic medical condition, live HIV or diabetes. As such, access to individual market health insurance products in Colorado is not a problem like it is in some other states, and while individual health insurance coverage is expensive everywhere due to rising medical costs and the market's limited ability to spread risk, premiums in Colorado are much less than in states

like Maine or New Jersey, where community rating and guaranteed issue of individual market products is required.

Health Savings Accounts

Our national office in Washington has been actively seeking positive changes to HSAs to smooth out some bumps in the road experienced by insurers, employers and consumers. NAHU supports these legislative through the HSA Working Group, a coalition of employers, insurers and others. We have identified a number of issues we believe are worth Congress' consideration and I have attached them to this testimony for your consideration. Some of the key changes we would like to see to federal HSA legislation include:

- Permitting individuals with a family HSA policy to meet the individual deductible requirements, rather than the whole family deductible.
- Permit an employee to contribute to a HAS even if his//her spouse has an FSA.
- Exempt HSAs from COBRA for ERISA purposes as they are now exempt for tax code purposes.
- Require the Department of Treasury to provide indexing of contribution amounts, out-of-pocket limits and deductibles earlier in the calendar year. Currently the indexing is issued in December, which is too late or many employers.
- Allowing adjustments to the HSA deductible requirements and contribution limits for employees who enroll at different times during the calendar year.
- Allowing individuals over age 65 to contribute to an HSA as long as they are not yet retired, even though they may automatically be enrolled in Medicare Part A.

Medical Liability Reform

NAHU has long supported efforts to pass medical liability reform. The threat of lawsuit abuse often forces physicians to perform invasive and expensive tests in order to protect themselves from frivolous lawsuits. Medical liability expenses are estimated to cost the country $24 billion each year, which is passed directly on to the consumer in the form of higher health insurance premiums. As such, we believe that federal legislation is needed to limit medical liability. Medical liability reforms that limit non-economic damage awards, allocate damages in proportion to degree of fault; place reasonable limits on punitive damages and attorney fees with a statute of limitations on claims would all have a positive impact on medical liability insurance premium rates. If medical liability insurance costs were lower it would likely reduce the health care costs associated with the practice of defensive medicine. In addition, state authorities should do a better job disciplining incompetent doctors, thereby reducing costs associated with their liability rates and medical errors. We applaud the U.S. House of Representatives for repeatedly passing commonsense medical malpractice liability reform measures, and will continue to work to have similar legislation passed by the U.S. Senate.

Thank you again for this opportunity to provide information about my association's views on health insurance access and affordability measures, both on a national basis and here in Colorado. If you have any questions, I would be happy to answer them.

Committee on Small Business
Testimony

Health Care and Small Business – Real Options for Colorado Businesses

Thursday, August 10, 2006 at 1:00 p.m.
Loveland City Council Chambers
500 East 3rd Street, Loveland, CO 80537

Testimony Prepared By:
Gail A. Snyder
Bob Snyder Insurance Agency, Inc.
1135 N. Lincoln Ave., #2, Loveland, CO 80537
970-461-5060

Purpose: Examine and draw attention to real alternatives and improvements to the health care market.

Requested Focus:
Health Savings Accounts (H.S.A.)
Association Health Plans (A.H.P.)
HR 2355 – Health Care Choice Act of 2005

Health Savings Accounts (H.S.A.)

Since the introduction of Health Savings Accounts, HSA's, the health insurance industry has undergone several changes – as has the insured community. The industry is seeing a tremendous increase in the number of businesses and individuals purchasing qualifying high deductible health plans. Employers are saving between 20 and 40 percent off their monthly premiums and many are passing some of that savings on to their employees by assisting in funding the employees' Health Savings Account. For employers who are already offering health insurance to their employees as a benefit this has become a viable cost containing effort. I commend the creativity and foresight that brought these to the industry. Thanks. This is a new and very useful tool in our belt!

Association Health Plans (AHP)

At first glance, Association Health Plans can be appealing, however once the plan is in place there is a high probability of rapidly increasing costs and diminished participants. Individuals wanting health insurance are typically better served through individual policies where there are fewer mandates in coverage and lower premiums. If these individuals are unable to obtain insurance on their own as individuals– they seek alternatives such as Group Insurance. When evaluating the cost of Group Insurance,

small business owners oftentimes see the premiums as unaffordable and cry out for an Association Health Plan, under the misconception that there will be lower premiums. These types of plans need to be entered into with tremendous caution. The benefit Group Insurance has over an Association Health Plan is the risk pool is much larger. An insurance carrier can offer a group plan to a state-wide audience of tens of thousands, whereas an Association Health Plan may be offered to only a few hundred. The rates are based upon participation and claims. A single catastrophic health condition, such as a premature baby, can be tolerated much better at the group level than it can for an Association Health Plan. A single shock claim could raise the Association Health Plan premiums to the degree that participation would rapidly decrease. This leaves an even smaller risk pool behind to tolerate the cost of health care. It becomes a death spiral for the Association Health Plan.

A potential alternative to consider would be for professional business associations to be considered a "group" for the purpose of purchasing group health insurance. The association, however, would bear the responsibilities of the "employer" in such a setting. Such liabilities could become unbearable to the association and cause it to default. I would not encourage such action without tremendous research and extensive test cases.

Not sure if you wanted to include any other issues with AHP's, but here is one other negative:

- A national AHP proposal could create guaranteed issue coverage for BG1's nationally. It has been proven disastrous in Colorado and other states that have or have tried guaranteed issue insurance for BG1, due to problems with both adverse selection and fraud. Allowing BG1's to purchase AHP coverage will prove equally problematic, increasing the likelihood of plan failure and resulting in significant cost increases for all state small group market participants.

HR 2355 – Health Care Choice

This legislation is being considered for the purpose of allowing individuals to purchase health insurance across state lines. There are several states that have passed over-burdening legislation for the health insurance industry and have caused a crisis situation for their respective states. This legislation has been conceived as a mechanism to bail them out of their own mire. While Colorado has plenty of onerous laws regarding health insurance, I sincerely do not believe this is the solution. Each of these states needs to recognize the difficult situation they are in and attempt to reverse some of their previously misconceived health insurance initiatives. These states who have mandated themselves out of the industry simply need to fix it themselves. The legislators need to take responsibility for the quagmire they are in. And, to every legislator who believes he or she has a new "very important" mandate to add to the insurance industry in Colorado – think again. Every mandate comes with a cost.

This legislation also brings about tremendous licensing issues. Currently, insurance brokers are licensed in their respective states, with some agents licensed in multiple states. In order to sell a particular plan, where does that agent need his or her

license to be active. It may also increase state costs for the purpose of standardizing insurance licensing.

For the consumer, this legislation has an even greater potential problem. In order for this to be successful, the insurance carrier must have access to nationwide network of providers. If a nationwide network is not available, it likely becomes an out of network expense raising the potential out of pocket to much higher levels. If networks were eliminated and "reasonable and customary" charges were again utilized this could be at least somewhat more viable.

Note - Rising Cost of Health Insurance:
The cost of health insurance continues to increase for two very simple reasons.

First – MANDATES:

Every single mandated coverage comes with a cost. The more mandates we experience, the higher the cost. Please, stop the process of adding mandated coverages!

Second – REDUCED PARTICIPATION

Every time insurance rates go up, participation drops. When insurance participation drops, charity cases become more prevalent for doctors and hospitals. This then drives billable costs up which insurance rates increase. Essentially – the fewer people we have insured the more insurance will cost and vice versa.

Recommendation:
I do not – in any way, shape or form – endorse a nationalized system for health care. What I do recommend, however, is a watchful eye on Massachusetts and plan to utilize test cases, rather than hypothetical situations.

We cannot mandate financial wisdom. We cannot mandate financial stability. We cannot mandate responsibility.
America has become a country of spend now – go bankrupt later. This has become the land of Jubilee!
--- and at what cost? ---

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